

DED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7927 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO.		c. CITY OR TOWN ST. LOUIS, MO	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. #1		d. STREET ADDRESS (If outside (give location)) 2419 N. GARFIELD	

3. NAME OF DECEASED (Type or print) First Middle Last 4. DATE OF DEATH Month Day Year

STEELE **7 / 24 / 60**

5. SEX **MALE** 6. COLOR OR RACE **NEGRO** 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH **7/24/60** 9. AGE (last birthday) IF UNDER 1 YEAR IF UNDER 24 HR

Months Days **2** **18**

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **ns** 10b. KIND OF BUSINESS OR INDUSTRY **none** 11. BIRTHPLACE (City and state or country) **ST. LOUIS, MO** 12. CITIZEN OF WHAT COUNTRY **U.S.A.**

13a. FATHER'S NAME **HOWARD** 13b. MOTHER'S MAIDEN NAME **PEARLINE WHITNEY** 14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If **NO** give war or dates of service) **NO** 16. SOCIAL SECURITY NO. **NONE** 17. INFORMANT Address **ST. LOUIS CITY HOSP. #1.**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Immaturity**

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) **776x** DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days. Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.

20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from **7/24/60** to **7/24/60** and last saw **him** alive on **7/24/60**

Death occurred at **12:10** **pm.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) **William Donald Richardson M.D.** 22b. ADDRESS **1515 Lafayette Ave.** 22c. DATE SIGNED **7-24-60**

23a. BURIAL, CREMATION, REMOVAL (Specify) **AUG 31 1960** 23b. NAME OF CEMETERY OR CREMATORY **Anatomical Board** 23c. LOCATION (City, town, or county) (State) **St. Louis, Mo.**

24. FUNERAL DIRECTOR ADDRESS **Rowland Mortuary Svc. 4104-06 Manchester** 25. DATE RECD. BY LOCAL REG. **AUG 11 1960** 26. REGISTRAR'S SIGNATURE **Carl Smith, M.D.**

DOCUMENT

MEDICAL CERTIFICATION

AFFIDAVIT OF

mjs

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: * The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a **STUDENT**, he also shall sign in his **OWN handwriting**.

If this body is not embalmed, fact should be so stated above.