

|  |   |   |   |   |  |   |  |  |  |
|--|---|---|---|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY   |   |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY |  |   |  |  |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>St. Louis</u>  |   | Length of stay in 1b  |   | c. CITY OR TOWN <u>St. Louis</u>  |  | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>   |  |  |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>Mo. Baptist Hospital</u>   |   |   | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |   | d. STREET ADDRESS (If outside, give location)<br><u>2709a Blair</u>      |   | Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>TERESA</u> Middle <u>KATHERINE</u> Last <u>DODSON</u>  |   |   |   | 4. DATE OF DEATH<br>Month <u>Sept</u> Day <u>14</u> Year <u>1960</u>  |  |   |  |  |  |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>White</u>  | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><u>9/7/1960</u>   | 9. AGE (last birthday)<br><u>0</u>                                       |   | IF UNDER 1 YEAR<br>Months <u>0</u> Days <u>7</u>                           | IF UNDER 24 HR<br>Hours <u>  </u> Min. <u>  </u> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>INFANT</u>   |   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>*****</u>                         |   | 11. BIRTHPLACE (City and state or country)<br><u>St. Louis, Missouri</u> |   | 12. CITIZEN OF WHAT COUNTRY<br><u>U.S.A.</u>                               |  |  |
| 13a. FATHER'S NAME<br><u>Joseph Dodson</u>   |   |   | 13b. MOTHER'S MAIDEN NAME<br><u>Odell Marshall</u>                        |   |  | 14. NAME OF HUSBAND OR WIFE<br>_____  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>NO</u>  |   | 16. SOCIAL SECURITY NO.<br><u>NONE</u>  |   | 17. INFORMANT<br><u>Joseph Dodson 2709 Blair</u>  |  |   |  | Address  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory failure</u>   |   |   |   |   |  |   | INTERVAL BETWEEN ONSET AND DEATH   |  |  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) <u>Prematurity + Immaturity</u>   |   |   |   |   |  |   | 7 days   |  |  |
| DUE TO (c) <u>7735</u>   |   |   |   |   |  |   |  |  |  |
| 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.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |  |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)  |   |   |  |   |  |  |  |
| 20c. TIME OF INJURY<br>Hour _____ a.m. _____ p.m.<br>Month, Day, Year _____  |   |   |   |   |  |   |  |  |  |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 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 <u>9-7-60</u> to <u>9-14-60</u> and last saw her/him alive on <u>9-14-60</u><br>Death occurred at <u>8:15 am</u> on the date stated above, and to the best of my knowledge, from the causes stated. |   |   |   |   |  |   |  |  |  |
| 22a. SIGNATURE (Degree or title)<br><u>Robert L Korn MD</u>  |   |   |   | 22b. ADDRESS<br><u>1502 Meramee Clayton Mo</u>  |  |   | 22c. DATE SIGNED<br><u>9-15-60</u>   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Removal</u>  |   | 23b. DATE<br><u>Sept 15 1960</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>New Bethlehem Cemetery</u>       |   | 23d. LOCATION (City, town, or county)<br><u>St. Louis, Ganty</u>         |   | (State)  |  |  |
| 24. FUNERAL DIRECTOR<br><u>BEIDERWIEDEN FUNERAL HOME INC.,</u>   |   |   |   | 25. DATE RECD. BY LOCAL REG.<br><u>SEP 15 1960</u>  |  | 26. REGISTRAR'S SIGNATURE<br><u>Earl Smith. M.D.</u>  |  |  |  |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 *Not Embalmed*  
*D. M. Esher*

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.