

FILED VS. SEP 21 1960

318

1003

=60-036069

Registration District No. Primary Registration District No. Registrar's No. 9094

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	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. #1		d. STREET ADDRESS 2838 CLARK (If outside, give location)	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last BABY GIRL EASTLING			4. DATE OF DEATH Month Day Year AUG. 22, 1960		
FEMALE	6. COLOR RACE NEGRO	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8/20/60	9. AGE (last birthday)	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		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 UNKNOWN		13b. MOTHER'S MAIDEN NAME ROBERTA EASTLING		14. NAME OF HUSBAND OR WIFE	
--------------------------------------	--	--	--	-----------------------------	--

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

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) Congenital atelectasis					
DUE TO (b) Prematurity					
DUE TO (c) 76.2-5					

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Interatrial septal defect			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
---	--	--	--	--	--

19. WAS AUTOPSY PERFORMED? 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 Hour a.m. p.m.	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 **8/20/60** to **8/22/60** and last saw her/him alive on **8/22/60**
Death occurred at **7:10 A** m 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 8/22/60		
---	--	--	---	--	--	------------------------------------	--	--

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 9-30-60	23c. NAME OF CEMETERY OR CREMATORY Anatomical Board		23d. LOCATION (City, town, or county) St. Louis, Mo.		(State)	
---	-----------------------------	---	--	--	--	---------	--

24. FUNERAL DIRECTOR ADDRESS Rowland-Aker Mortuary Service		25. DATE RECD. BY LOCAL REG. SEP 15 1960		26. REGISTRAR'S SIGNATURE Roan Smith, M.D.	
--	--	--	--	--	--

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 _____, Student Embalmer No. _____ 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.