URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED NOV 3 1960

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10358

60-039607
STATE FILE NUMBER

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST.LOUIS,MO
Length of stay in 1b
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): ST.LOUIS CITY HOSP. #1.
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo.
b. COUNTY
c. CITY OR TOWN: ST.LOUIS,MO
Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 5104 ENRIGHT
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: GREG; Middle: CARNES; Last:

4. DATE OF DEATH: Month: OCT.; Day: 20; Year: 1960

5. SEX: MALE

6. COLOR OR RACE: NEGRO

7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 10/20/60

9. AGE (last birthday)

IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HR: Hours: 2 Min.: 20

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): no

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: GEORGE CARNES

13b. MOTHER'S MAIDEN NAME: RUTH MEEKS

14. NAME OF HUSBAND OR WIFE: —

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT Address: ST.LOUIS CITY HOSP. #1.

MEDICAL CERTIFICATION

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):
DUE TO (c): 776x
INTERVAL BETWEEN ONSET AND DEATH:

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 a.m. p.m. Month, Day, Year

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 10/20/60 to 10/20/60 and last saw her/him alive on 10/20/60
Death occurred at 8:20 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Wilma Clarenman M.D.

22b. ADDRESS: 1515 LAFAYETTE AVE

22c. DATE SIGNED: 10/20/60

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE: 10-31-1960

23c. NAME OF CEMETERY OR CREMATORY: Anatomical Board

23d. 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.: OCT 26 1960

26. REGISTRAR'S SIGNATURE: Hoard Smith, M.D.

BY AFFIDAVIT OF DOCUMENT

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_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No._____

P. O. Address_____

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