RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-60-043192
STATE FILE NUMBER

ILED VS NOV 1 6 1960 Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 224

DED

1. PLACE OF DEATH
a. COUNTY ST CHARLES
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST CHARLES — Length of stay in 1b 12 HRS
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST Josephs Hospital — Inside Limits Yes ☑ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MO b. COUNTY ST LOUIS
c. CITY OR TOWN ELMDALE — Inside Limits Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location) 9001 McNULTY — Reside on Farm Yes ☐ No ☑

3. NAME OF DECEASED (Type or print) First RALPH Middle C Last DRISKILL
4. DATE OF DEATH Month 11 Day 4 Year 60

5. SEX MALE
6. COLOR OR RACE WHITE
7. Married ☐ Never Married ☑ Widowed ☐ Divorced ☐
8. DATE OF BIRTH 11-4-60
9. AGE (last birthday) — IF UNDER 1 YEAR Months Days — IF UNDER 24 HR Hours 12 Min.

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

13a. FATHER'S NAME RALPH DRISKILL
13b. MOTHER'S MAIDEN NAME FLORENCE ST. CIN
14. NAME OF HUSBAND OR WIFE NONE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. NONE
17. INFORMANT Address RALPH DRISKILL 9001 McNULTY

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Premature infant (7 months) — INTERVAL BETWEEN ONSET AND DEATH 12 hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) (2 lbs 3 oz)
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 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 11-4-60, to and last saw her/him alive on 11-4-60, 8:00 pm
Death occurred at m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Gerald C. Jaeger, MD
22b. ADDRESS 2nd & Clay, St. Charles, Mo.
22c. DATE SIGNED 11-5-60

23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL
23b. DATE 11-5-60
23c. NAME OF CEMETERY OR CREMATORY MT LEBANON
23d. LOCATION (City, town, or county) (State) ST ANN MO.

24. FUNERAL DIRECTOR EARL Allcman ADDRESS OVERLAND MO
25. DATE RECD. BY LOCAL REG. Nov. 5-60
26. REGISTRAR'S SIGNATURE Marcella Wilson

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

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 Not Embalmed, Student Embalmer No.

working under my personal supervision.

Student _____ Signed Earl Hillenm

Signature of Student Embalmer

Licensed Embalmer No. 3501

P. O. Address Overlan

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.