

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Missouri		a. STATE Illinois b. COUNTY Madison	
Length of stay in 1b 38 days		c. CITY OR TOWN Venice	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis Children's		d. STREET ADDRESS (If outside, give location) 36 Lee Wright Homes	

3. NAME OF DECEASED (Type or print) First Middle Last Beverly Ann Baker			4. DATE OF DEATH Month Day Year 11 11 60		
5. SEX female	6. COLOR OR RACE colored	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9-15-57	9. AGE (last birthday) 3 years	IF UNDER 1 YEAR Months Days
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) Illinois	
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME J.C. Baker		13b. MOTHER'S MAIDEN NAME Earnstean Crawford	
14. NAME OF HUSBAND OR WIFE none		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 Address Mary Ritter 500 S Kingshighway			

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) Cardiac arrest		
DUE TO (b) 2° to Wilms tumor & metastasis.		
DUE TO (c) Mephrotoxy 180x		
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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)
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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
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21. I attended the deceased from **10-4-60** to **11-11-60** and last saw her/him alive on **11-11-60**.
Death occurred at **4:02 am** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Gemma P. [Signature]</i>	22b. ADDRESS Children's Hospital	22c. DATE SIGNED 11/11/60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 11/12/60	23c. NAME OF CEMETERY OR CREMATORY Booker Washington	23d. LOCATION (City, town, or county) East St. Louis, Illinois
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24. FUNERAL DIRECTOR Marshall Funeral Home - E. St. Louis, Ill.	25. DATE REC'D. BY LOCAL REG. NOV 12 1960	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.
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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 *Anna M. [Signature]*

Licensed Embalmer No. 4479

P. O. Address East St. Louis,

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.