

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 <u>St. Louis, Mo.</u>		Length of stay in 1b	c. CITY OR TOWN <u>ST. LOUIS, MO</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Louis City Hosp. #1</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS <u>5632 CABANNE</u> <u>ST. LOUIS, MO</u>
		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Baby Boy</u> Middle <u>ROBERT FRANK</u> Last <u>Mills</u>			4. DATE OF DEATH Month <u>12</u> Day <u>25</u> Year <u>1960</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12/23/60</u>	9. AGE (last birthday) IF UNDER 1 YEAR Months <u>2</u> Days <u></u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	11. BIRTHPLACE (City and state or country) <u>ST. LOUIS, MO</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>	

13a. FATHER'S NAME <u>ROBERT MILLS</u>		13b. MOTHER'S MAIDEN NAME <u>RUBY CRISP</u>		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) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>ST. LOUIS CITY HOSP. #1.</u>	
				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) <u>Asphyxia</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			
DUE TO (b) <u>Hypoxic Membrane Disease</u>			
DUE TO (c) <u>Prematurity</u> <u>762.5</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. <input type="checkbox"/> Yes <input checked="" 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 <u></u> a.m. <u></u> p.m. <u></u>	Month, Day, Year <u>12/23/60</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>12/25/60</u>	COUNTY	STATE
21. I attended the deceased from <u>3:45</u> <u>AM</u> on <u>12/23/60</u> to <u>12/25/60</u> and last saw her/him alive on <u>12/25/60</u> Death occurred at <u>3:45</u> <u>AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.						

22a. SIGNATURE <u>Loard Smith M.D.</u> (Degree & title)			22b. ADDRESS <u>1515 Lafayette Ave.</u>		22c. DATE SIGNED <u>12/25/60</u>	
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>JAN 31 1961</u>	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY <u>Anatomical Board</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>
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24. FUNERAL DIRECTOR <u>Rowland Mortuary Svc.</u> ADDRESS <u>4104-56 Manchester</u>		25. DATE RECD. BY LOCAL REG. <u>JAN 5 1961</u>	26. REGISTRAR'S SIGNATURE <u>Loard Smith, M.D.</u>	
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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
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
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.