

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>ST. LOUIS</u>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis, Mo</u>		c. CITY OR TOWN <u>JENNINGS</u>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Luke's Hospital</u>		d. STREET ADDRESS (if outside, give location) <u>2717 KINAMORE DR</u>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>BABY Kreuter</u>			4. DATE OF DEATH Month <u>12</u> Day <u>9</u> Year <u>60</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>12-9-60</u>	9. AGE (last birthday)	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>St. Louis, Mo</u>		11. BIRTHPLACE (City and state or country) <u>USA</u>	

13a. FATHER'S NAME <u>NORBERT FRED Kreuter</u>		13b. MOTHER'S MAIDEN NAME <u>Constance Ruth Bertelsmeyer</u>		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mother</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ATHECTASIS</u>			INTERVAL BETWEEN ONSET AND DEATH <u>25 MINUTES</u>
DUE TO (b) <u>PREMATURITY - 25 WEEKS Gestation</u>			
DUE TO (c) <u>761.5</u>			

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Premature Placental Separation Rupture Amniotic Sac</u>			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		
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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.)	
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20c. TIME OF INJURY Hour <u>11:25 PM</u> a.m. p.m.	Month, Day, Year <u>Dec. 9, 1960</u>
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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 <u>St. Louis, Mo.</u>	COUNTY	STATE
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21. I attended the deceased from 11:25 PM Dec. 9, 1960 to 11:50 Dec. 9, 1960 and last saw her/him alive on DECEMBER 9, 1960
 Death occurred at 11:50 PM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>William J. McEnnis M.D.</u>	(Degree or title)	22b. ADDRESS <u>8230 Dorseth</u>	22c. DATE SIGNED <u>Dec. 13, 1960</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>1-31-61</u>	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY <u>Anatomical Board</u>	23d. LOCATION (City, town, or county) <u>St. Louis, Mo.</u>
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24. FUNERAL DIRECTOR <u>Rowland Mortuary Svc. 4104-06 Manchester</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>JAN 26 1961</u>	26. REGISTRAR'S SIGNATURE <u>Paul 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 by _____
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.