

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

VS JAN 16 1961
AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 212-61-002844 STATE FILE NUMBER

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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				Length of stay in 1b		c. CITY OR TOWN	
St. Louis				3 DYS.		Kirkwood Mo.	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION				Inside Limits Yes ☒ No ☐		d. STREET ADDRESS (If outside, give location) 326 Aldridge	
ST. JOHN'S HOSPITAL				Yes ☒ No ☐		Yes ☐ No ☐	
3. NAME OF DECEASED (Type or print) First Middle Last				4. DATE OF DEATH Month Day Year			
BABY BLACKWELL				Jan. 6 1961			
5. SEX	6. COLOR OR RACE	7. Married ☐ Widowed ☐	Never Married ☒ Divorced ☐	8. DATE OF BIRTH	9. AGE (last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HR
FEMALE	NEGR			1/3/61	—	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		11. BIRTHPLACE (City and state or country)	
						St. Louis Mo. USA	
12. CITIZEN OF WHAT COUNTRY							
13a. FATHER'S NAME				13b. MOTHER'S MAIDEN NAME		14. NAME OF HUSBAND OR WIFE	
				EVON BLACKWELL			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address	
						Acie Blackwell 326 Aldridge	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SUBARACHNOID HEMORRAGE DUE TO (b) 2NDARY to PREMATURITY DUE TO (c) BIRTH WEIGHT 1LB 7 ounces 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.) 760.5			
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	
JAN 1, 1961		DEC 31, 1960		JAN 6TH 1961		JAN 5, 1961	
21. I attended the deceased from _____ to _____ and last saw her alive on _____ 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) Philip C. Higgins M.D.				22b. ADDRESS 307. S Euclid.		22c. DATE SIGNED 1/7/61	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
Burial		1/9.1961		Father Dickson Cem.		Crestwood Mo.	
24. FUNERAL DIRECTOR ADDRESS John W. Hemphill 408 S. Fillmore				25. DATE RECD. BY LOCAL REG. JAN 9 1961		26. REGISTRAR'S SIGNATURE Karl Smith, M.D.	

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

John H. Hemphill
No Embalming
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.