

DATE AMENDED
 AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

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		b. STATE MISSOURI b. COUNTY ST. LOUIS	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DEACONESS HOSPITAL		c. CITY OR TOWN (UNINCORPORATED)	
Length of stay in 1b		d. STREET ADDRESS 4030 GREEN MEADOW DRIVE	
3. NAME OF DECEASED (Type or print) First Middle Last INFANT KING		4. DATE OF DEATH Month Day Year JANUARY 21, 1961	
5. SEX FEMALE	6. COLOR OR RACE CAUCASIAN	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1/21/1961
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE	9. AGE (last birthday) IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. 1 15
11. BIRTHPLACE (City and state or country) ST. LOUIS, MISSOURI		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME GALE KING		13b. MOTHER'S MAIDEN NAME DOROTHY WILLIAMS	
14. NAME OF HUSBAND OR WIFE NEVER MARRIED		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 GALE KING	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hydrothorax		INTERVAL BETWEEN ONSET AND DEATH 40 min.	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Ascites		40 min.	
DUE TO (c) 770.0			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Polyhydramnios and Toxemia of Pregnancy		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.)	
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	
21. I attended the deceased from 1/21/61 to 1/21/61 and last saw her ^{her} _{him} alive on 1/21/61 Death occurred at 3:40 PM on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) W. D. Hawker, MD		22b. ADDRESS 36 Hampton Village Plaza	22c. DATE SIGNED 1/23/61
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	23b. DATE 1/24/1961	23c. NAME OF CEMETERY OR CREMATORY MISSOURI CREMATORY	23d. LOCATION (City, town, or county) (State) ST. LOUIS, MISSOURI
24. FUNERAL DIRECTOR ADDRESS HOPFMEISTER COLONIAL MORTUARY 6464 CHIPPEWA STREET ST. LOUIS, MISSOURI		25. DATE REC'D. BY LOCAL REG. JAN 25 1961	26. REGISTRAR'S SIGNATURE Neal 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

Eric C. Hanson

Licensed Embalmer No.

4964

P. O. Address

St Louis Mo

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.