SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS MAR 13 1961 318 Registration District No. 1003 Primary Registration District No. 1003 Registrar's No. 2083 -61-011329 STATE FILE NUMBER

AMENDED

DATE AMENDED | INSTEAD OF | SHOULD READ | ITEM NO. | DOCUMENT | BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MO b. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo | Length of stay in 1b

c. CITY OR TOWN ST. Louis | Inside Limits Yes ☐ No ☐

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Luke's Hospital | Inside Limits Yes ☐ No ☐

d. STREET ADDRESS (If outside, give location) 5575 WATERMAN | Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First Middle Last: BABY NOLAN

4. DATE OF DEATH Month Day Year: FeB. 10 61

5. SEX: MALE

6. COLOR OR RACE: White

7. Married ☐ Never Married ☑ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: FeB 9-61

9. AGE (last birthday) | IF UNDER 1 YEAR Months Days | IF UNDER 24 HR Hours 6 Min. 20

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.

12. CITIZEN OF WHAT COUNTRY: USA

13a. FATHER'S NAME

13b. MOTHER'S MAIDEN NAME: MIRIAM M. NOLAN

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)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mother | Address St Louis 12, Mo 5575 WATERMAN

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) intracranial hemorrhage

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) birth trauma

DUE TO (c) 760.0

INTERVAL BETWEEN ONSET AND DEATH

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.)

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

21. I attended the deceased from 2-9-61, to 2-10-61 and last saw her/him alive on 2-10-61.
Death occurred at 1:55A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Kathleen Winters M.D.

22b. ADDRESS: 457 N. Kingshighway

22c. DATE SIGNED: 2-10-61

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE: MAR 31 1961

23c. NAME OF CEMETERY OR CREMATORY: Anatomical Board

23d. LOCATION (City, town, or county) (State): St. Louis, Mo.

24. FUNERAL DIRECTOR ADDRESS: Rowland Mortuary Svc. 4104-06 Manchester

25. DATE RECD. BY LOCAL REG.: MAR 2 1961

26. REGISTRAR'S SIGNATURE: Earl 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_____ Signed_____
Signature of Student Embalmer

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.