MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3769 61-015211 STATE FILE NUMBER

FILED APR 27 1961

AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO.	SHOULD READ	INSTEAD OF	DATE AMENDED

BY AFFIDAVIT OF DOCUMENT

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis, Missouri
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Jewish Hospital
Inside Limits Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Illinois
b. COUNTY
c. CITY OR TOWN: East St. Louis
Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 720 Brady Avenue
Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First: Baby Boy Middle: Last: Harrington
4. DATE OF DEATH Month: 3 Day: 20 Year: 61
5. SEX: Male
6. COLOR OR RACE: Negro
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 3-20-61
9. AGE (last birthday)
IF UNDER 1 YEAR Months Days
IF UNDER 24 HR Hours: 3 Min.: 39
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, Missouri
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: James Wesley Harrington
13b. MOTHER'S MAIDEN NAME: Iola M. Mitchell
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: James Harrington Address: 720 Brady, East St. Louis Ill

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): Atelectasis
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Prematurity
DUE TO (c): 762.5
INTERVAL BETWEEN ONSET AND DEATH: 3 hr 39 m
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 3-20-61 to 3-20-61 and last saw her him alive on 3-20-61
Death occurred at 1:30 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE: Robert Dunstan MD. (Degree or title)
22b. ADDRESS: 100 N Euclid St Louis
22c. DATE SIGNED: 3-31-61
23a. BURIAL, CREMATION, REMOVAL (Specify)
23b. DATE: APR 29 1961
23c. NAME OF CEMETERY OR CREMATORY: Anatomical Board
23d. LOCATION (City, town, or county) (State): St. Louis, Mo.
24. FUNERAL DIRECTOR: Rowland Aker ADDRESS: 4104 Manchester
25. DATE RECD. BY LOCAL REG.: APR 20 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.