

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

3777-61-015321
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. _____

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

FILED APR 27 1961

1. PLACE OF DEATH
a. COUNTY _____
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Missouri Length of stay in lb _____
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 Missouri b. COUNTY St. Louis
c. CITY OR TOWN WEBSTER GROVES - 19 Inside Limits Yes No
d. STREET ADDRESS (If outside, give location) 34 North Old Orchard Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First BABY Middle BOY Last KITE 4. DATE OF DEATH Month 3 Day - 14 Year - 61

5. SEX MALE 6. COLOR OR RACE W 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH 3-14-61 9. AGE (last birthday) IF UNDER 1 YEAR IF UNDER 24 HR. Months _____ Days _____ Hours 5 Min. 6

10a. USUAL OCCUPATION (Give kind of work done, during most of working life, even if retired) None 10b. KIND OF BUSINESS OR INDUSTRY None 11. BIRTHPLACE (City and state or country) St. Louis, Missouri 12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME Russell B. Kite 13b. MOTHER'S MAIDEN NAME MARILYN RAGAN 14. NAME OF HUSBAND OR WIFE None

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. None 17. INFORMANT Russell Kite, 34 N. Old Orchard, Webster Groves, Mo. Address _____

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary insufficiency INTERVAL BETWEEN ONSET AND DEATH birth
DUE TO (b) Prematurity birth
DUE TO (c) 754.5

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 3-14-61 to 3-14-61 and last saw him alive on 3-14-61
Death occurred at 11:39 P. M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Robert C. Schaan MD (Degree or title) 22b. ADDRESS 9293 Watson St. K 22c. DATE SIGNED 4/17/61 (State) _____

23a. BURIAL, CREMATION, REMOVAL (Specify) _____ 23b. DATE April 29-1961 23c. NAME OF CEMETERY OR CREMATORY Anatomical Board 23d. LOCATION (City, town, or county) St. Louis, Mo.

24. FUNERAL DIRECTOR Rowland Mortuary Svc. 4104-06 Manchester ADDRESS _____ 25. DATE RECD. BY LOCAL REG. APR 20 1961 26. REGISTRAR'S SIGNATURE Loard Smith. M.D.

WJ 274
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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 _____

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.