

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

8199-61-034211
STATE FILE NUMBER

Registration District No. 18 Primary Registration District No. 1003 Registrar's No. 8199

AMENDED
FILED SEP 18 1961 318

DATE AMENDED

INSTEAD OF THIS RECORD ARE AS FOLLOWS

SHOULD READ

DOCUMENT

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. Louis</u>		c. CITY OR TOWN <u>ST. Louis</u>	
Length of stay in 1b		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. ANTHONYS Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>2845 Ohio</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Delay</u> Last			4. DATE OF DEATH Month <u>Sept.</u> Day <u>1</u> Year <u>1961</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 1, 1961</u>
9. AGE (last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min. <u>13</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>Dallas Delay</u>	
13b. MOTHER'S MAIDEN NAME <u>Carol Sue Wilson</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Dallas Delay</u>		Address <u>2845 Ohio</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fatal Anoxia</u>			INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) <u>Prematurity</u>			
DUE TO (c) <u>Abrupt Placental 761.5</u>			
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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 <u>9/1/61</u> to <u>9/1/61</u> and last saw her ^{her} _{him} alive on <u>9/1/61</u> Death occurred at <u>11:15</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Robert A. Brennan M.D.</u>		22b. ADDRESS <u>3606 Gravois</u>	22c. DATE SIGNED <u>9-4-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Sept. 5, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST. Matthew's Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>ST. Louis, Mo.</u>
24. FUNERAL DIRECTOR <u>Witt Bros. L.L.C.</u>	ADDRESS <u>6409 Gravois</u>	25. DATE RECD. BY LOCAL REG. <u>SEP 5 1961</u>	26. REGISTRAR'S SIGNATURE <u>Keat Smith M.D.</u>

DR. BRENNEN

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 NOT Embalmed, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Harold C. Witt

Licensed Embalmer No. 4353

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.