

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-039489
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 3133

LED NOV 15 1961

1. PLACE OF DEATH a. COUNTY <u>St Louis County Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>mo</u> b. COUNTY <u>St Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clayton</u> Length of stay in 1b		c. CITY OR TOWN <u>Western Groves</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>County Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>916 Emma</u> Reside on Farm <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Baby Boy</u> Middle <u>Douglas</u> Last			4. DATE OF DEATH Month <u>10</u> Day <u>20</u> Year <u>61</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>negro</u>	7. Married <input type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10-20-24</u>	9. AGE (last birthday) IF UNDER 1 YEAR Months <u>4</u> Days <u>4</u> Hours <u>4</u> Min.	IF UNDER 24 HR	
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) <u>Clayton, mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>
13a. FATHER'S NAME <u>Winfred Douglas</u>		13b. MOTHER'S MAIDEN NAME <u>Gloria Howell</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)		16. SOCIAL SECURITY NO.		17. INFORMANT 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) <u>Immaturity</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c)	
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 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 <u>8:25</u> a.m. <u>8</u> p.m.	Month <u>10</u> Day <u>20</u> Year <u>61</u>		
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 10-20-61 to 10-20-61 and last saw ^{her} him alive on 10-20-61
Death occurred at 8:25 P on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Edward T. Barber M.D.</u>	22b. ADDRESS <u>601 So Brentwood</u>	22c. DATE SIGNED <u>10/25/61</u>
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23a. BURIAL, CREMATION, REMOVAL (City or county) <u>Cremation</u>	23b. DATE <u>11-8-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>City Crematory</u>	23d. LOCATION (City, town, or county) (State) <u>St Louis Mo</u>
24. FUNERAL DIRECTOR <u>County Hosp.</u>	ADDRESS <u>Clayton Mo</u>	25. DATE RECD. BY LOCAL REG. <u>11-7-61</u>	26. REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</u>

(Licensed Embalmer's Statement on Reverse Side)

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

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.