SOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-042904
STATE FILE NUMBER

AMENDED •

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11128

FILED DEC 12 1961

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

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MO. b. COUNTY
c. CITY OR TOWN ST.LOUIS
Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location) 912A NO 21 ST.
Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First DAVID Middle LAMONT Last SMITH
4. DATE OF DEATH Month NOV. Day 8, Year 1961
5. SEX MALE
6. COLOR OR RACE NEGRO
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH 11/8/61
9. AGE (last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours 14 Min. 4
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none
10b. KIND OF BUSINESS OR INDUSTRY n one
11. BIRTHPLACE (City and state or country) st.louis mo
12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME JAMES MILLER SMITH
13b. MOTHER'S MAIDEN NAME WILLIE JEAN CAPER
14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. none
17. INFORMANT ST.LOUIS CITY HOSP. #1. Address

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) Congenital atelectasis
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Immaturity
DUE TO (c) 762.5
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 11/7/61, to 11/8/61 and last saw her/him alive on 11/8/61
Death occurred at 7:50 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Gerard Duling M.D. (Degree or title)
22b. ADDRESS 1515 LAFAYETTE AVE
22c. DATE SIGNED 11/8/61

23a. BURIAL, CREMATION, REMOVAL (Specify)
23b. DATE NOV 30 1961
23c. NAME OF CEMETERY OR CREMATORY Anatomical Board
23d. LOCATION (City, town, or county) (State) St. Louis, Mo.

24. FUNERAL DIRECTOR Rowland Mortuary Svc. ADDRESS 4104-06 Manchester
25. DATE RECD. BY LOCAL REG. NOV 30 1961
26. REGISTRAR'S SIGNATURE [illegible] M.D.

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

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 com 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.