SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-047816

TMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12485

FILED JAN 25 1962

1. PLACE OF DEATH
a. COUNTY ST. LOUIS
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS — Length of stay in 1b
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Home 2626 Virginia — Inside Limits Yes ☑ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo b. COUNTY Mo
c. CITY OR TOWN ST. LOUIS — Inside Limits Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location) 2629 VIRGINIA — Reside on Farm Yes ☐ No ☑

3. NAME OF DECEASED (Type or print) First Baby Middle Girl Last McGee

4. DATE OF DEATH Month 12 Day 23 Year 61

5. SEX F
6. COLOR OR RACE W
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH 12-23-61
9. AGE (last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min. unknown

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant
10b. KIND OF BUSINESS OR INDUSTRY Infant
11. BIRTHPLACE (City and state or country) St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME Acil McGee
13b. MOTHER'S MAIDEN NAME Ruth Ann (Chapman) Ghen
14. NAME OF HUSBAND OR WIFE Infant

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 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) X Immaturity – 4½ mos gestation
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) premature rupture membranes
DUE TO (c) 761.5
INTERVAL BETWEEN ONSET AND DEATH: Unknown

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. X I attended the deceased from X No signs of life when seen @ ½ hr after birth – family states gasping & movements present at birth to and last saw her/him alive on
Death occurred at Dec 23, 1961 m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) X Mary L. Gray M.D.
22b. ADDRESS X Furnish Desloge Hosp.
22c. DATE SIGNED X Jan 19, '62

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE 1-22-62
23c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery
23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri

24. FUNERAL DIRECTOR ADDRESS McLaughlin 2301 Lafayette Ave St. Louis, 4, Missouri
25. DATE RECD. BY LOCAL REG. JAN 20 1962
26. REGISTRAR'S SIGNATURE Carl Smith, M.D.

DATE AMENDED 9/2 — INSTEAD OF — DOCUMENT — SHOULD READ — ITEM NO. — BY AFFIDAVIT OF — MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was NOT embalmed by me,

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed H. S. Harris

Signature of Student Embalmer

Licensed Embalmer No. 3384

P. O. Address St Louis

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.