

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-004071

STATE FILE NUMBER

AMENDED

Registered District No. 7-318 Primary Registration District No. 1003 Registrar's No. 1376

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, Missouri</u>		Length of stay in 1b		c. CITY OR TOWN <u>St. Louis - 39</u>		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>Jewish Hospital</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>5400 ARSENAL ST.</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>BABY GIRL KROTANKER</u>			4. DATE OF DEATH Month Day Year <u>1 - 5 - 62</u>					
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>W</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>1-4-62</u>	9. AGE (last birthday) <u>2</u>	IF UNDER 1 YEAR Months Day Hours Min. <u>7 2 33</u>	IF UNDER 24 HR Hours Min. <u>2 33</u>	
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>St. Louis, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>ROSE J. KROTANKER</u>			13b. MOTHER'S MAIDEN NAME <u>ROSALIE WOLANSKY</u>		14. NAME OF HUSBAND OR WIFE			
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 <u>ROSALIE KROTANKER, 5400 ARSENAL, ST. LOUIS 39</u> 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>Hyaline Membrane Disease</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.) DUE TO (b) _____ DUE TO (c) <u>773.0</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>1-4-62</u> to <u>1-5-62</u> and last saw her/him alive on <u>1-5-62</u> Death occurred at <u>5:45</u> <u>A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>Walter Schwarty MD</u>			22b. ADDRESS <u>950 Francis Place, Clayton</u>			22c. DATE SIGNED <u>1-12-62</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>JAN 31 1962</u>		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY <u>Anatomical Board</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>		
24. FUNERAL DIRECTOR <u>Rowland New 40 Manchester</u> ADDRESS			25. DATE RECD. BY LOCAL AGEN. <u>JAN 31 1962</u>		26. REGISTRAR'S SIGNATURE <u>Paul Smith, M.D.</u>			

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 3 29
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF
 ITEM NO. SHOULD READ

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.