

This Child followed in our institution since March 15, 1962
MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-016987

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

1003

4296

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. _____ Registrar's No. _____

FILED MAY 1 1962

VS 300
 Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

Check item on top

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Missouri			Length of stay in 1b 15 hours		c. CITY OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis Children's Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 620 N. Taylor
3. NAME OF DECEASED (Type or print) First Keith Middle NMN Last Kyles			4. DATE OF DEATH Month 4- Day 24- Year 62		
5. SEX Male	6. COLOR OR RACE Negro	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12-21-61	9. AGE (last birthday) 4mo	IF UNDER 1 YEAR Months 4 Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (City and state or country) St. Louis, Missouri USA	
12. CITIZEN OF WHAT COUNTRY		13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Mary Alice Mickens	
14. NAME OF HUSBAND OR WIFE None		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Doris Mason		Address 500 S Kingshighway			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY					INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Cardiac Arrest Respirator Failure					
DUE TO (b) hydrocephalus & Holter Valve					
DUE TO (c) Streptococcal meningitis					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Brain Abscess					
PART III. If deceased was female was there a pregnancy in last 90 days. 340.2					<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 _____ 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 4-23-62 to 4-24-62 and last saw her/him alive on 4-24-62 Death occurred at 2:45 A m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE Malcolm Barber MD			22b. ADDRESS Children's Hospital		22c. DATE SIGNED 4-25-62
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 4/26/62	23c. NAME OF CEMETERY OR CREMATORY FATHER DIEKSON		23d. LOCATION (City, town, or county) (State) ST. LOUIS, CO., MO.
24. FUNERAL DIRECTOR W. Robinson & Sons: 2911 Franklin			25. DATE RECD. BY LOCAL REG. APR 25 1962		26. REGISTRAR'S SIGNATURE Loan Smith, M.D.

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 Leroy W. Zimmerman

Licensed Embalmer No. 4523

P. O. Address 1251 Washington

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.