

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED SEP 4 1962 317

-62-033307  
STATE FILE NUMBER

Registration District No. Primary Registration District No. 547 Registrar's No. 2442

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

1 4005  
2 4018  
3 2  
4 1  
5 0  
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7 0  
8 2  
9 7735  
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12 46-0  
13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Richmond Heights</b>		Length of stay in 1b <b>36 Hrs.</b>	c. CITY OR TOWN <b>Bridgeton</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Marys Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>12170 Nottingham</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Baby 'B' Nancy Ann Whitnall</b>			4. DATE OF DEATH Month Day Year <b>Aug 20, 1962</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>8/19/62</b>
10a. USUAL OCCUPATION (Give kind of work done)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) <b>36 hrs</b> IF UNDER 1 YEAR: Months <b>1 1/2</b> Days Hours Min.
11. BIRTHPLACE (City and state or country) <b>Richmond Heights, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Edward Whitnall</b>		13b. MOTHER'S MAIDEN NAME <b>Loretta Dietz</b>	14. NAME OF HUSBAND OR WIFE <b>Single</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Edward Whitnall 12170 Nottingham</b> 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) <b>Respiratory Distress Syndrome (Hyaline Membrane Disease)</b> DUE TO (b) <b>Prematurity</b> DUE TO (c) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>36 hrs</b>
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 <b>8/19/62</b> to <b>8/20/62</b> and last saw her/him alive on <b>8/20/62</b> Death occurred at <b>3:30 pm</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>James K. Young, M.D.</b> (Degree or title)		22b. ADDRESS <b>101 S. Marquette, Clayton, Mo</b>	22c. DATE SIGNED <b>8/21/62</b>
22a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <b>8/23/1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>
24. FUNERAL DIRECTOR <b>Collier's Mortuary St. Ann, Mo.</b> ADDRESS		25. DATE RECD. BY LOCAL REG. <b>8-22-62</b>	26. REGISTRAR'S SIGNATURE <b>John B. Murphy M.D.</b>

USE BLACK INK OR TYPEWRITER RIBBON

**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 \_\_\_\_\_

*[Handwritten signature of student embalmer]*  
Signature of Student Embalmer

Signed \_\_\_\_\_

*[Handwritten signature of licensed embalmer]*

Licensed Embalmer No. \_\_\_\_\_

*3382*

P. O. Address \_\_\_\_\_

*St. Ann, Mo*

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.