

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

7644  
1300

State File No. ....

4883  
FILED FEB 25 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. ....

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. LENGTH OF STAY (In this place)		2059	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Lukes Hospital		d. STREET ADDRESS (If rural, give location) 1055 Hamilton	
3. NAME OF DECEASED (Type or Print)	a. (First) Sandra	b. (Middle) Lou	c. (Last) Hinshaw
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH 1-12-53
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	9b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday)	10. DATE OF DEATH (Month) (Day) (Year) 1-16-53
10a. USUAL OCCUPATION	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St. Louis, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Russell Kenneth Hinshaw	13b. MOTHER'S MAIDEN NAME Dorothy Frances Mc Cabe	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Dorothy Frances Mc Cabe Hinshaw, 1055 Hamilton	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prematurity - Neo-Natal Death		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Premature Delivery - 36 wks DUE TO (c) -		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 776 Y
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22. I hereby certify that I attended the deceased from 1-12, 1953, to 1-16, 1953, that I last saw the deceased alive on 1-16, 1953, and that death occurred at 10:20 a. m., from the causes and on the date stated above.

23a. SIGNATURE John J. Alloggan Jr. M.D.	(Degree or title)	23b. ADDRESS 5535 Wilmar Blvd.	23c. DATE SIGNED 1-26-53
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 2-18-53	24c. NAME OF CEMETERY OR CREMATORY Anatomical Board	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
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DATE REC'D BY LOCAL REG. FEB 4 1953	REGISTRAR'S SIGNATURE J. Carl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Rowland Mortuary Service	ADDRESS
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WRITE PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

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**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.....

.....  
working under my personal supervision.

Student Embalmer No.....

Signed.....

Signed.....  
Student Embalmer

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 this body is not embalmed, fact should be so stated above.