

FILED APR 2 1949

STANDARD CERTIFICATE OF DEATH

State File No. 10948

BIRTH NO. 49-026313 REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 3069 Registrar's No. 572

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY ST LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MO b. COUNTY ST LOUIS	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Richmond Heights		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Creland	
c. LENGTH OF STAY (in this place) 0		d. STREET ADDRESS (If rural, give location) 10565 Hobday	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST MARYS HOSPITAL			

3. NAME OF DECEASED (Type or Print)	a. (First) INFANT	b. (Middle)	c. (Last) Smith	4. DATE OF DEATH (Month) (Day) (Year) 3 2 49
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single	8. DATE OF BIRTH 3-1-49	9. AGE (In years last birthday) 0	IF UNDER 1 YEAR Months 1	IF UNDER 11 HRS. Days 1	IF UNDER 1 HRS. Hours 12	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) nil	10b. KIND OF BUSINESS OR INDUSTRY nil	11. BIRTHPLACE (State or foreign country) Richmond Heights	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME Ralph Smith	13b. MOTHER'S MAIDEN NAME Marie Morrow	14. NAME OF HUSBAND OR WIFE
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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'S SIGNATURE OR NAME: Ralph Smith	ADDRESS: 10565 Hobday
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 20 hrs
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Disseminated Atelectasis Neoratorum		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) 7620 DUE TO (c) 121a		
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 type="checkbox"/> NO <input checked="" 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) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 3/1, 1949, to 3/2, 1949, that I last saw the deceased alive on 3/1, 1949, and that death occurred at 4:45 a.m., from the causes and on the date stated above.

23a. SIGNATURE Roy V. Boedeker MD (Degree or title)	23b. ADDRESS 4500 Olive (8)	23c. DATE SIGNED 3/2/49
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24a. BURIAL, CREMATION, REMOVAL (Specify) buried	24b. DATE 3-3-49	24c. NAME OF CEMETERY OR CREMATORY Georgie Cemetery	24d. LOCATION (City, town, or county) (State) Pallouville MO
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DATE REC'D BY LOCAL REG. 2-2-49	REGISTRAR'S SIGNATURE Thurmond B. Surrage	25. FUNERAL DIRECTOR'S SIGNATURE William B. Bowers	ADDRESS 1555 S. Woodson
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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.....

..... Student Embalmer No.

working under my personal supervision.

Signed: Oscar F Mueller

Signed.....
Student Embalmer

Licensed Embalmer No. 3039

P. O. Address Overland 142

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.