

FILED JUL 25 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 24775

BIRTH NO. 44659-49 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 6052

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MD		b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give town) St. Louis		c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. John's Hospital		d. STREET ADDRESS (If rural, give location) 7628 S. Broadway			
3. NAME OF DECEASED (Type or Print) Baby		a. (First) Baby		b. (Middle) Infant	
		c. (Last) Faust		4. DATE OF DEATH (Month) (Day) (Year) July - 9 1949	
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) infant		8. DATE OF BIRTH July 9, 1949	
9. AGE (In years last birthday)		10. KIND OF BUSINESS OR INDUSTRY no		11. BIRTHPLACE (State or foreign country) St. Louis mo	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) no		10b. KIND OF BUSINESS OR INDUSTRY no		11. BIRTHPLACE (State or foreign country) St. Louis mo	
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME Joe Faust		13b. MOTHER'S MAIDEN NAME Elizabeth Rost	
14. NAME OF HUSBAND OR WIFE no		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT'S SIGNATURE OR NAME Joe Faust		17. ADDRESS 7628 S. Broadway			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prematurity			INTERVAL BETWEEN ONSET AND DEATH 3 hours
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) 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 type="checkbox"/> NO <input checked="" type="checkbox"/>
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) 139	
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? 776X	
22. I hereby certify that I attended the deceased from July 9th 1949, to July 9th 1949, that I last saw the deceased alive on July 9th 1949, and that death occurred at 7 A. M., from the causes and on the date stated above.					
23a. SIGNATURE John J. Hennelly M.D.		23b. ADDRESS 16 Hampton Village Plaza		23c. DATE SIGNED 7/10/49	
24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE 7/11/49		24c. NAME OF CEMETERY OR CREMATORY Mt. Olive Ce.	
		24d. LOCATION (City, town, or county) (State) Lemay 23, Mo.			
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE JUL 11 1949 J. B. Bassett		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Fendler Und. Co., 7420 Michigan			

*St. John Hosp - 11 Ave
Dr. Hennelly -*

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 _____

No Embalming

Student Embalmer No. _____

working under my personal supervision.

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