

FILED JUL 25 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25369

State File No.

6063

BIRTH NO. 36632-49 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No.

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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 death) a. STATE <u>Missouri</u> b. COUNTY <u>St. Charles</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis - Mo</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>O'Fallon</u>	
c. LENGTH OF STAY (In this place) <u>15 days</u>		d. STREET ADDRESS (If rural, give location) <u>NR - R.R.#1</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Louis Children's Hospital</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Richard</u> b. (Middle) <u>Albert</u> c. (Last) <u>Vomund</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>7-9-49</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never Married</u>	8. DATE OF BIRTH <u>June-21-1949</u>
9. AGE (In years last birthday) <u>0</u> IF UNDER 1 YEAR Months <u>18</u> IF UNDER 4 HRS. Hours <u>0</u> Min. <u>0</u>		11. BIRTHPLACE (State or foreign country) <u>St. Charles - Missouri</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13a. FATHER'S NAME <u>Charles N. Vomund</u>		13b. MOTHER'S MAIDEN NAME <u>Dorothy Vomund</u>	
14. NAME OF HUSBAND OR WIFE <u>None</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>Charles Vomund, O'Fallon, Mo.</u>		ADDRESS	
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, asphyxia, 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) <u>Starvation</u>			
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Multiple atresias of small intestine - technically inoperable</u>			
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 type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., to or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>157m</u>			
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? <u>7562</u>			
22. I hereby certify that I attended the deceased from <u>June 24, 1949</u> , to <u>July 9, 1949</u> , that I last saw the deceased alive on <u>July 9, 1949</u> , and that death occurred at <u>1:30 p. m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>Dr. L. Thurston</u>		23b. ADDRESS <u>Childrens Hospital</u>	
23c. DATE SIGNED <u>7-9-49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>7-10-49</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>St. Paul</u>		24d. LOCATION (City, town, or county) (State) <u>St. Paul Mo</u>	
DATE REC'D BY LOCAL <u>JUL 11 1949</u>		REGISTRAR'S SIGNATURE <u>J. B. Susater</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Albert H. Hoppe</u>		ADDRESS <u>4700 Washington Blvd.</u>	

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
Student Embalmer

Signed No Embalm _____

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.