

FILED OCT 6 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 32384

BIRTH NO. 46256-49 REG. DIST. NO. 1917 PRIMARY REG. DIST. NO. 18063 Registrar's No. 2171

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. (Parents) COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Clayton		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Overland	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis County Hospital		d. STREET ADDRESS (If rural, give location) 10208 St. Kathryn	

3. NAME OF DECEASED (Type or Print) BABY GIRL			4. DATE OF DEATH (Month) (Day) (Year) June 29 1949		
a. (First)	b. (Middle)	c. (Last)	5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED
8. DATE OF BIRTH 6-29-49	9. AGE (In years last birthday) 1	If UNDER 1 YEAR Months 0	If UNDER 24 HRS. Hours 1	Min. 30	12. CITIZEN OF WHAT COUNTRY? U.S.A.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) Missouri D	

13a. FATHER'S NAME Wm. Gover		13b. MOTHER'S MAIDEN NAME Helen Nichols		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS St. Louis County Hospital Clayton	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Premature birth		INTERVAL BETWEEN ONSET AND DEATH 17 hours	
*This does not mean the mode of dying, such as heart failure, asthma, 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. 776X	

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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)	
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?	

22. I hereby certify that I attended the deceased from June 29, 19 49, to June 29, 19 49, that I last saw the deceased alive on June 29, 19 49, and that death occurred at 11 am., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) R.P. Cahle M.D.		23b. ADDRESS 601 S. Brentwood, Clayton		23c. DATE SIGNED 7-9-49	
24a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		24b. DATE 9-15-49		24c. NAME OF CEMETERY OR CREMATORY St. Louis City	
24d. LOCATION (City, town, or county) (State) St. Louis Mo		25. FUNERAL DIRECTOR'S SIGNATURE Richard P. Hanks, M.D.		ADDRESS St. Louis City Infirmary	

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

6
1027

LAM-7

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 _____

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.