

FILED APR 10 1950

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **10181**
3132
 Registrar's No. _____

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003	
1. PLACE OF DEATH a. COUNTY _____			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE: Mo. b. COUNTY _____		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		c. LENGTH OF STAY (in this place) _____	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		2019
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis Children Hosp			d. STREET ADDRESS (If rural, give location) 7108 Virginia Ave.		
3. NAME OF DECEASED (Type or Print) a. (First) Kathleen		b. (Middle) Diane	c. (Last) Bobes	4. DATE OF DEATH (Month) (Day) (Year) 3 31 50	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 0	8. DATE OF BIRTH July 3, 1946	9. AGE (In years last birthday) 3	IF UNDER 1 YEAR Months 8 Days 28
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) St Louis Mo		12. CITIZEN OF WHAT COUNTRY? 0
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Esther Bobes	14. NAME OF HUSBAND OR WIFE None		
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 Esther Bobes 7108 Virginia Ave.		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, assthenia, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute leukemia ANTECEDENT CAUSES DUE TO (b) _____ DUE TO (c) _____ Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. II. OTHER SIGNIFICANT CONDITIONS. Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND 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) St Louis Mo			
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? 2041			
22. I hereby certify that I attended the deceased from 3-21, 1950 , to 3-30, 1950 , that I last saw the deceased alive on 3-30, 1950 , and that death occurred at 2:13Am. , from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) Wm G Klingberg MD		23b. ADDRESS St Louis Children Hospital		23c. DATE SIGNED 3-31-50	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE April 3, 50	24c. NAME OF CEMETERY OR CREMATORY Mt. Hope	24d. LOCATION (City, town, or county) (State) Lemay, Mo.		
DATE REC'D BY LOCAL REG. MAR 31 1950	REGISTRAR'S SIGNATURE J. B. Lusater		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Fendler Undertaking 7420 Michigan		

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

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 VE Morris

Licensed Embalmer No. 3360

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.