

FILED JUL 29 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 24786

Registrar's No. 6159

BIRTH NO. 44138-57 #102149

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 Missouri		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 2229	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1.		d. STREET ADDRESS (If rural, give location) 920 La Salle St.,			
3. NAME OF DECEASED (Type or Print)		a. (First) Infant		b. (Middle)	
		c. (Last) Gentile		4. DATE OF DEATH (Month) (Day) (Year) July 17th, 1950	
5. SEX Male		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single	
8. DATE OF BIRTH July 15th, 1950		9. AGE (In years last birthday)		10. # UNDER 1 YEAR 2	
11. # UNDER 24 HRS. Min.		11. BIRTHPLACE (State or foreign country) St. Louis City Hospital #1.		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) newborn		10b. KIND OF BUSINESS OR INDUSTRY nil		13a. FATHER'S NAME Tony Overturp	
13b. MOTHER'S MAIDEN NAME Verna Vest		14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	
16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Y Tony Gentile		ADDRESS 920 Lasalle Street	
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) Cerebral anoxia		INTERVAL BETWEEN ONSET AND DEATH Life	
*This does not mean the mode of dying, such as heart failure, asphyxia, 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. Prematurity		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., 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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 773.5		22. I hereby certify that I attended the deceased from 7/15/50, 19__, to 7/17/50, 19__, that I last saw the deceased alive on 7/17/50, 19__, and that death occurred at 7:30 a.m., from the causes and on the date stated above.		23a. SIGNATURE J W Burroughs, MD	
23b. ADDRESS 1515 Lafayette Ave.,		23c. DATE SIGNED 7/17/50		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE 7/18/50		24c. NAME OF CEMETERY OR CREMATORY St. Matthew Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis Mo.	
DATE REC'D BY LOCAL REG. JUL 18 1950		REGISTRAR'S SIGNATURE J. B. Lasater		25. FUNERAL DIRECTOR'S SIGNATURE Morgan Funeral Home	
ADDRESS 1926 Allen Av.					

(Licensed Embalmer's Statement on Reverse Side)

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.....

not Embalmed

working under my personal supervision.

Student Embalmer No.....

Signed.....

Signed.....
Student Embalmer

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.