

FILED FEB 23 1951

## STANDARD CERTIFICATE OF DEATH

State File No. 6815

102744

318

1003

1237

BIRTH NO. 5487-51		REG. DIST. NO.		PRIMARY REG. DIST. NO. 1003		Registrar's No.			
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois b. COUNTY					
b. CITY (If outside corporate limits, write RURAL and give OR TOWN St. Louis, Mo.)		c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) East St. Louis		8128			
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1.				d. STREET ADDRESS (If rural, give location) 510 Senaca					
3. NAME OF DECEASED (Type or Print) Infant BABY			a. (First)		b. (Middle) WILLS		c. (Last)		
4. DATE OF DEATH Jan. 20th 1951		5. SEX male 0		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) single 0		8. DATE OF BIRTH 1/20/51	
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) nil		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) St. Louis City Hospital #1.		12. CITIZEN OF WHAT COUNTRY?	
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) nil		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) St. Louis City Hospital #1.		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME Clifford Wills			13b. MOTHER'S MAIDEN NAME Bonnie Mc Dermot			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 M. Renard, St. Louis City Hospital #1.				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.		1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Premature birth, neo-natal death MEDICAL CERTIFICATION ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Maternal trauma (pelvic fracture) DUE TO (c)						INTERVAL BETWEEN ONSET AND 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., 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? 776X							
22. I hereby certify that I attended the deceased from 1/20/51, 19___, to 1/20/51, 19___, that I last saw the deceased alive on 1/20/51, 19___, and that death occurred at 10:15pm, from the causes and on the date stated above.									
23a. SIGNATURE S. W. Burroughs (Degree or title) M.D.				23b. ADDRESS 1515 Lafayette Ave.,		23c. DATE SIGNED 1/22/51			
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 1/22/51		24c. NAME OF CEMETERY OR CREMATORY Anatomical Burial		24d. LOCATION (City, town, or county) (State)			
DATE REC'D BY LOCAL REG. FEB 9 1951		REGISTRAR'S SIGNATURE J. B. Foster		25. FUNERAL DIRECTOR'S SIGNATURE Rowland Mortuary Service Inc.		ADDRESS			

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

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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.....

.....  
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.