

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAY 12 1951

State File No.

| | | | | | | | | | | | | | | | |
|--|--|--|--|--|--------------------|---|--|---|--|---|--|--|--|---|--|
| BIRTH NO. | | REG. DIST. NO. 318 | | PRIMARY REG. DIST. NO. 1003 | | Registrar's No. 4109 | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY St. Louis b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis c. LENGTH OF STAY (In this place) 11-Hrs. d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis Children's Hospital | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Illinois b. COUNTY ? c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN CHRISTOPHER d. STREET ADDRESS (If rural, give location) 8 | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) KATHY b. (Middle) JEAN c. (Last) OLDANI | | | 4. DATE OF DEATH (Month) (Day) (Year) 4-28-51 | | 5. SEX FEM. | | | 6. COLOR OR RACE WHITE | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 1 | | 8. DATE OF BIRTH 4-26-51 | | 9. AGE (In years last birthday) 2 IF UNDER 1 YEAR Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country) Illinois | | | | 12. CITIZEN OF WHAT COUNTRY? Amer. | | | |
| 13a. FATHER'S NAME ANGELO OLDANI | | | | 13b. MOTHER'S MAIDEN NAME DOROTHY Hackl | | | | 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) | | | | 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT'S SIGNATURE OR NAME D. SHELLEE ADDRESS 500 S. KINGSHIGHWAY | | | | | | | |
| 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, asthenia, etc. It means the disease, injury, or complication which caused death. | | | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Birth Sclerema Neonatorum ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Birth injury extrauterine bleeding DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 days 2 days | | | |
| 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? 7600 | | | | | | | | | | | |
| 22. I hereby certify that I attended the deceased from 4-27 , 1951, to 4-28 , 1951, that I last saw the deceased alive on 4-28 , 1951, and that death occurred at 2:40 a.m. , from the causes and on the date stated above. | | | | | | | | | | | | | | | |
| 23a. SIGNATURE Dr. J. B. Lucater (Degree or title) | | | | 23b. ADDRESS 500 S. KINGSHIGHWAY | | | | 23c. DATE SIGNED 4-28-51 | | | | | | | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) | | 24b. DATE 4-28-51 | | 24c. NAME OF CEMETERY OR CREMATORY Christopher | | | | 24d. LOCATION (City, town, or county) (State) Ill | | | | | | | |
| DATE RECEIVED BY LOCAL REG. 1951 | | | | REGISTRAR'S SIGNATURE J. B. Lucater | | | | 25. FUNERAL DIRECTOR'S SIGNATURE Royal Mortuary Service Inc. ADDRESS 4104 Manchester Ave. St. Louis 10, Mo. | | | | | | | |

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

4109

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 Peter B. Dubrouillet

Signed
Student Embalmer

Licensed Embalmer No. 3691

P. O. Address Rehoboth Heights, Md.

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.