

FILED JUN 9 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 18545

BIRTH NO. 39439-51 REG. DIST. NO. 310 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 MISSOURI b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS 4376	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LOUIS MATERNITY HOSPITAL		d. STREET ADDRESS (If rural, give location) 8254 PARAMONT DRIVE	

3. NAME OF DECEASED (Type or Print) a. (First) b. (Middle) c. (Last)		4. DATE OF DEATH (Month) (Day) (Year)	
Baby SALDANA		MAY 19 1951	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH MAY 16 1951
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days 3 9 35
		11. BIRTHPLACE (State or foreign country) ST. LOUIS, MISSOURI	
		12. CITIZEN OF WHAT COUNTRY?	

13a. FATHER'S NAME NICANOR GALARZA SALDANA	13b. MOTHER'S MAIDEN NAME EMMA MARIE RUDOLPH	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 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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Erythroblastosis Fetalis		
	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.			

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? 770.0

22. I hereby certify that I attended the deceased from MAY 16, 1951, to MAY 19, 1951, that I last saw the deceased alive on MAY 19, 1951, and that death occurred at 10:45 PM, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) David N. McEwen M.D.	23b. ADDRESS 7803A Clayton	23c. DATE SIGNED 5-21-51
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE MAY 24 1951	24c. NAME OF CEMETERY OR CREMATORY Station Hill
		24d. LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REG. MAY 24 1951	REGISTRAR'S SIGNATURE J. B. Lanster	25. FUNERAL DIRECTOR'S SIGNATURE Rowland Service 4104 Manchester	ADDRESS
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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 \_\_\_\_\_

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.