

FILED JUN 9 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 18739
4311

BIRTH NO. 210291-51 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No.

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u>	c. LENGTH OF STAY (in this place)	c. CITY (If outside corporate limits, write RURAL and give township) <u>2619</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Thorsted Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>61 3746 E. Edgar</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>Baby Boy</u> b. (Middle) <u>Wilkinson</u> c. (Last) <u>Wilkinson</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>3. 31. 51</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <u>3/30/51</u>
9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country) <u>St. Louis Mo.</u>	12. CITIZEN OF WHAT COUNTRY?
13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME <u>Wilkinson</u>	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 <u>Michael Wilkinson</u> ADDRESS <u>3746 E. Edgar</u>	
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) <u>Prematurity</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Premature Labor</u> 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 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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>776X</u>	
22. I hereby certify that I attended the deceased from <u>Mar 30, 1951</u> , to <u>Mar 31, 1951</u> , that I last saw the deceased alive on <u>Mar 31, 1951</u> , and that death occurred at <u>2:42 A.M.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>Kenneth W. Larsen MD</u> (Degree or title)		23b. ADDRESS <u>607 N. Grand Ave.</u>	23c. DATE SIGNED <u>3-31-51</u>
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE <u>MAY 8 1951</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Anatomical Board</u>	24d. LOCATION (City, town, or county) (State)
DATE REC'D BY LOCAL REG. <u>MAY 9 1951</u>		REGISTRAR'S SIGNATURE <u>J. B. Lassiter</u>	25. FUNERAL HOME SIGNATURE <u>Rowland Mortuary Service Inc.</u> ADDRESS <u>4104 Manchester Ave. St. Louis 10, Mo.</u>

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.