FILED APR 16 1952

No. 300
10.48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 14216

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 2080

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ST. LOUIS MO
c. LENGTH OF STAY (in this place): 18 hrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST. LOUIS CHILDREN'S

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: MO
b. COUNTY: St. Louis
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Riverview Gardens 4010
d. STREET ADDRESS (If rural, give location): 10079 DIAMOND DR.

3. NAME OF DECEASED (Type or Print)
a. (First) RONALD b. (Middle) EUGENE c. (Last) DREWS

4. DATE OF DEATH (Month) (Day) (Year): March 4, 1952.

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): SINGLE
8. DATE OF BIRTH: 6-12-44
9. AGE (In years last birthday): 7 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: 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): ST LOUIS MO
12. CITIZEN OF WHAT COUNTRY?: AMERICA

13a. FATHER'S NAME: Clifford Drews
13b. MOTHER'S MAIDEN NAME: Marjorie Waltrop
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: Mr. Clifford M. Drews 10079 Diamond Drive

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) Encephalitis

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.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

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 ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-3, 1952, *to* 3-4, 1952 *that I last saw the deceased alive on* 3-4, 1952, *and that death occurred at* 5:30 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Don L. Thurston MD
23b. ADDRESS: Children's Hosp.
23c. DATE SIGNED: 3-4-52

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 3-7-52.
24c. NAME OF CEMETERY OR CREMATORY: Hickory Grove Cemetery
24d. LOCATION (City, town, or county) (State): Wrights, Illinois.

DATE REC'D BY LOCAL REG.: MAR 4 1952
REGISTRAR'S SIGNATURE: J Carl Smith MD
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Math Hermann & Son, Inc. 2161 E. Fair Ave.

(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.....

.....,

working under my personal supervision.

Student Embalmer No.....

Signed.....

Student Embalmer

Signed Homer W. Fritz

Licensed Embalmer No. 3882

P. O. Address St. Louis

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.