

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4089

State File No. _____

FILED FEB 10 1953
6201
BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 541 Registrar's No. 0362

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

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST. LOUIS</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>CLAYTON</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>KINLOCH</u>	
c. LENGTH OF STAY (In this place) <u>2 DAYS</u>		d. STREET ADDRESS (If rural, give location) <u>MONROE + COURTNEY</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. LOUIS COUNTY HOSPITAL</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Baby Boy</u>	b. (Middle)	c. (Last) <u>Whitten</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Jan 28 1953</u>
---	-------------	--------------------------	---

5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>1-26-53</u>	9. AGE (In years last birthday) <u>2</u>	IF UNDER 1 YEAR Months <u>2</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
--------------------	---------------------------------	--	---------------------------------	--	---------------------------------	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>CLAYTON Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
---	---	--	--

13a. FATHER'S NAME <u>NATH WHITTEN</u>	13b. MOTHER'S MAIDEN NAME <u>OLLIE LEE DAVENPORT</u>	14. NAME OF HUSBAND OR WIFE <u>None</u>
--	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>OLLIE LEE WHITTEN</u>	ADDRESS <u>KINLOCH Mo</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, asthma, 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) <u>Encephalic atresia of lung</u>		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Renal agenesis</u> DUE TO (c) <u>Prematurity</u>		
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 <u>774X</u>	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)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
---	--	----------------------------

22. I hereby certify that I attended the deceased from 1-26, 1953, to 1-28, 1953, that I last saw the deceased alive on 1-28, 1953, and that death occurred at 2:30 A.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Harold L. Robinia M.D.</u>	23b. ADDRESS <u>6015 Brentwood, Clayton 5 Mo.</u>	23c. DATE SIGNED <u>1-29-53</u>
--	---	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>	24b. DATE <u>1-30-53</u>	24c. NAME OF CEMETERY OR CREMATORY <u>ST. LOUIS CREMATORY</u>	24d. LOCATION (City, town, or county) (State) <u>ARSENAL ST. LOUIS Mo</u>
--	--------------------------	---	---

DATE REC'D BY LOCAL REG. <u>1-30-53</u>	REGISTRAR'S SIGNATURE <u>Herbert R. Donks Mo</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>St. Louis County Hospital</u>	ADDRESS <u>Clayton</u>
---	--	---	------------------------

Not Embalmed

C. H. Lohr, M.D.

Curtis H. Lohr, M.D.
Supt. & Med. Dir. St. Louis County Hesperia

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.