

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6038

91922-53
FILED MAR 11 1954

State File No. _____

1585

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

1. PLACE OF DEATH a. COUNTY ST. LOUIS, MO		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 town) OR TOWN SAINT LOUIS		c. CITY OR TOWN SAINT LOUIS	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) 2 1/2 MOS		e. STREET ADDRESS (If rural, give location) 3586 ST. JOACHIM	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LOUIS CHILDREN'S			

3. NAME OF DECEASED (Type or Print) a. (First) CYNTHIA b. (Middle) LOUISE c. (Last) COLE	4. DATE OF DEATH (Month) (Day) (Year) 2 17 54
--	---

5. SEX FEM	6. COLOR OF RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) SINGLE	8. DATE OF BIRTH 11-30-53	9. AGE (In years last birthday) 21 MONTHS 21 DAYS	10. IF UNDER 18 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 (City and State or Foreign Country) ST. LOUIS MO	12. CITIZEN OF WHAT COUNTRY? U.S.A
---	-----------------------------------	--	---

13a. FATHER'S NAME ERNEST C. COLE	13b. MOTHER'S MAIDEN NAME BEATRICE ORF	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 J. EGAN ADDRESS 500 So 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, 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) Diarrhea		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Intestinal atresia + operation 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 Ileal atresia + postop malfunctioning + seg. postop obstruction	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) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 7593
--	--	--

22. I hereby certify that I attended the deceased from **11-30**, 19**53**, to **2-17**, 19**54**, that I last saw the deceased alive on **2-17**, 19**54**, and that death occurred at **11:30 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE Wm G Klingberg (Degree or title) MD	23b. ADDRESS 6107 So Kingshighway	23c. DATE SIGNED 2/18/54
--	--	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE FEB. 20, 1954	24c. NAME OF CEMETERY OR CREMATORY ST. PAUL CEMETERY	24d. LOCATION (City, town, or county) (State) ST. PAUL MO.
---	--------------------------------	---	---

DATE REC'D BY LOCAL REG. FEB 18 1954	REGISTRAR'S SIGNATURE J. Earl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Collins Funeral Home ADDRESS 10123 St. Charles Rd.
---	---	---

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 Student Embalmer No. working under my personal supervision..

Student
Signature of Student Embalmer

Signed *Sheldon Collins*

Licensed Embalmer No. *330*

P. O. Address *10123 St.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.