

FILED AUG 2 - 1954

STANDARD CERTIFICATE OF DEATH

State File No. 24258  
Registrar's No. 6768

BIRTH NO. 42337-54 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY		
b. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis, Mo.</u>		c. LENGTH OF STAY (In this place)	c. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Booth Memorial Hosp.</u>			d. STREET ADDRESS (If rural, give location) <u>23 1000 A. Park Ave</u>		
3. NAME OF DECEASED (Type or Print) a. (First) <u>ROBERT</u> b. (Middle) <u>EMERSON</u> c. (Last) <u>BEQUETTE, JR.</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>7-16-54</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <u>7-12-54</u>		9. AGE (In years last birthday) IF UNDER 1 YEAR Months IF UNDER 1 YEAR Days IF UNDER 1 HRS. Hours Mins. <u>4</u>
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) <u>St. Louis Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>0</u>

13a. FATHER'S NAME <u>Robt. E. Bequette</u>		13b. MOTHER'S MAIDEN NAME <u>Doris Spradling</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 ADDRESS <u>Mr. Robt. E. Bequette (Father)</u>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Atelectasis - Pulmonary</u>		DUE TO (b) <u>Prematurity</u>			
* This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		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 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) <u>762.5</u>	
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?	

22. I hereby certify that I attended the deceased from 7-12, 1954, to 7-16, 1954, that I last saw the deceased alive on 7-16, 1954, and that death occurred at 7:16 a.m., from the causes and on the date stated above.

23a. SIGNATURE <u>Charles J. ...</u>		(Degree or title) <u>M.D.</u>		23b. ADDRESS <u>3740 Marine Ave.</u>		23c. DATE SIGNED <u>16 July 1954</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <u>7-31-54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Anatomical Board</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>	

DATE REC'D BY LOCAL REG. <u>JUL 22 1954</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S NAME AND ADDRESS <u>Rowland Aker Mortuary Service</u> 4104 Manchester Ave.	
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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 \_\_\_\_\_

working under my personal supervision.

Student Embalmer No. ....

Signed \_\_\_\_\_

Signed .....  
Student Embalmer

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.