

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **32256**

BIRTH NO. **66050-54** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **8231**

1. PLACE OF DEATH a. COUNTY		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 township) St. Louis		c. CITY OR TOWN Ferguson	d. In 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) 1 Day		e. STREET ADDRESS (If usual, give location) /	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Lukes Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Deborah b. (Middle) Kay c. (Last) Summers			4. DATE OF DEATH (Month) (Day) (Year) Sept. 5, 1954.			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Sept. 4, 1954.	9. AGE (In years last birthday) 1	IF UNDER 1 YEAR Months 9	IF UNDER 18 MTS. Days 9
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nihil		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? U. S.

13a. FATHER'S NAME Tommy L. Summers		13b. MOTHER'S MAIDEN NAME Wardena M. Fitch		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) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Tommy L. Summers, Ferguson, Mo.	

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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Erythroblastosis Fetalis</i>  ANTECEDENT CAUSES <i>Rh factor incompatibility</i> DUE TO (b)  DUE TO (c)  II. OTHER SIGNIFICANT CONDITIONS <i>Anemia due to above</i>		INTERVAL BETWEEN ONSET AND DEATH	
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19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		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? 7700	

22. I hereby certify that I attended the deceased from Sept 4, 1954 to Sept 5, 1954 that I last saw the deceased alive on Sept 5, 1954, and that death occurred at 6:46 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <i>William D. McInnis MD</i>		23b. ADDRESS 3720 Washington		23c. DATE SIGNED Sept 7, 1954	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 9/7/54		24c. NAME OF CEMETERY OR CREMATORY Laurel Hill Gardens		24d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.	
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DATE REC'D BY LOCAL REG. SEP 7 1954		REGISTRAR'S SIGNATURE <i>Carl Smith MD</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>White Chapel, Ferguson, Mo.</i>		ADDRESS	
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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 *L. M. White*.....

Licensed Embalmer No. *397*

P. O. Address *Pergine*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.