

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. **39347**
 Registrar's No. **10160**

FILED NOV 22 1954

318

1003

BIRTH NO. **84213-54** REG. DIST. NO.

PRIMARY REG. DIST. NO.

Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Anthony		d. STREET ADDRESS (If rural, give location) 15 5503 Virginia	
3. NAME OF DECEASED (Type or Print) a. (First) Denise Kay b. (Middle) c. (Last) Weigand			4. DATE OF DEATH (Month) (Day) (Year) Nov 8 54
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) infant	8. DATE OF BIRTH 11/7/54
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 1 HR. Hours Min. 1
11. BIRTHPLACE (State or foreign country) St. Louis Mo.		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Ervin Weigand		13b. MOTHER'S MAIDEN NAME Geraldine Bailey	14. NAME OF HUSBAND OR WIFE Infant
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. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Geraldine Weigand 5503 Virginia Ave.
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) Pulmonary atelectasis INTERVAL BETWEEN ONSET AND DEATH 1 da ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Premature (33 wks) 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)	
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? 7625	
22. I hereby certify that I attended the deceased from Nov 7, 1954 , to Nov 8, 1954 , that I last saw the deceased alive on Nov 8, 1954 , and that death occurred at 6:15 p.m. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) George A. O'Sullivan, M.D.		23b. ADDRESS 421 W. Schurmer	23c. DATE SIGNED 11-9-54
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 11/9/54	24c. NAME OF CEMETERY OR CREMATORY New St. Marcus	24d. LOCATION (City, town, or county) (State) St. Louis Co Mo
DATE REC'D BY LOCAL REG. NOV 9 1954	REGISTRAR'S SIGNATURE J. Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wm Schumacher 3013 Meramec	

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

(Licensed Embalmer's Statement on Reverse Side)

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 _____

Jack H. [Signature]

Licensed Embalmer No. _____

P. O. Address _____

*4746
St. James St.*

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.