

STANDARD CERTIFICATE OF DEATH

FILED APR 14 1955

State File No. _____

BIRTH NO. 25766-55 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 2967

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo</u> b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (in this place) <u>2 da.</u>		c. CITY OR TOWN <u>St. Louis</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>De PAUL Hosp</u>		e. STREET ADDRESS (If rural, give location) <u>4 1107 TAMM 20470</u>			
3. NAME OF DECEASED (Type or Print) <u>INFANT MARY THERESE GAGNE</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>4 - 1 - 55</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 29 1955</u>		9. AGE (In years last birthday) <u>3</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE - INFANT</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis, Mo.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13a. FATHER'S NAME <u>Wilfred Gagne</u>		13b. MOTHER'S MAIDEN NAME <u>Anita Honne</u>	
14. NAME OF HUSBAND OR WIFE <u>-</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>J. M. F. Venne</u>		18. ADDRESS <u>1107 Tamm Av.</u>			

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Intracranial hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last: DUE TO (b) <u>Prematurity</u>		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 checked="" 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>7605</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 3/29 1955, to 3/31, 1955, that I last saw the deceased alive on 3/31, 1955, and that death occurred at 9:45 a.m., from the causes and on the date stated above.

23a. SIGNATURE Hickson Oto, M.D. (Degree or title) 23b. ADDRESS 634 No Grand 23c. DATE SIGNED 4/1/55

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 24b. DATE APR 2 1955 24c. NAME OF CEMETERY OR CREMATORY SS PETER + PAUL CEM. 24d. LOCATION (City, town, or county) (State) ST LOUIS MO.

DATE REC'D BY LOCAL REG. APR 1 1955 REGISTRAR'S SIGNATURE J. Carl Smith, M.D. FUNERAL DIRECTOR'S SIGNATURE (Croghan) ADDRESS 7146 MANCHESTER ST LOUIS 17 MO.

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

Not Embalmed
[Handwritten Signature]

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