

FILED MAY 12 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

14235

State File No. ....

BIRTH NO. _____		REG. DIST. NO. <u>317</u>		PRIMARY REG. DIST. NO. <u>547</u>		Registrar's No. <u>999</u>	
1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u> (inclusion).			
b. CITY (If outside corporate limits, write RURAL and give OR township) <u>Richmond Heights</u>		c. LENGTH OF STAY (In this place) <u>1 day</u>		c. CITY OR TOWN <u>Vinita Park #270</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Mary's Hospital</u>				STREET ADDRESS (If rural, give location) <u>1739 North &amp; South Road</u>			
3. NAME OF DECEASED (Type or Print) <u>Baby</u>		a. (First)		b. (Middle)		c. (Last) <u>Phelps</u>	
4. DATE OF DEATH <u>April 30 1955</u>		(Month)		(Day)		(Year)	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>SINGLE</u>		8. DATE OF BIRTH <u>April 30 1955</u>	
9. AGE (In years last birthday) _____		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 11 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR IN- DUSTRY <u>NONE</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Ray Phelps</u>		13b. MOTHER'S MAIDEN NAME <u>Margaret Whalen</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>			
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. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Ray Phelps 1739 North &amp; South Rd.</u>			
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 dis- ease, injury, or complica- tion which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Hydrocephalus - Spina Bifida</u>				INTERVAL BETWEEN ONSET AND DEATH	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Unknown</u>					
		DUE TO (c) <u>(Child only, lived above 3 hrs)</u>					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death <u>see above -</u>					
19a. DATE OF OPERA- TION		19b. MAJOR FINDINGS OF OPERATION <u>No operation - Spontaneous Delivery 751X</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE (Specify) HOMICIDE <u>780</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>St. Louis</u>		21c. (CITY, TOWN, OR TOWNSHIP) <u>St. Louis</u> (COUNTY)		(STATE)	
21d. TIME OF INJURY <u>None</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>None</u>			
22. I hereby certify that I attended the deceased from on <u>Apr. 29 - 1955</u> , that I last saw the deceased alive on <u>Apr 29, 1955</u> , and that death occurred at <u>10 P. m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>E. Lee North M.D.</u> (Degree or title)				23b. ADDRESS <u>Univ. City</u>		23c. DATE SIGNED <u>Apr 30 '55</u>	
24a. DATE <u>5/2/55</u>		24b. DATE <u>5/2/55</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Calvary</u>		24d. LOCATION (City, town, or county) <u>St. Louis Mo.</u> (State)	
DATE REC'D BY LOCAL REG. <u>5/3/55</u>		REGISTRAR'S SIGNATURE <u>Hubert R. Donker M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Sullivan's 2849 No. Euclid Ave.</u> ADDRESS			

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

Mr. E. W. Barrett  
8505 Belmont  
May 1, 1900

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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 ....., Student Embalmer No. .... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Albert Wayfield*  
Licensed Embalmer No. *307*

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.