

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **23415**
Registrar's No. **6216**FILED AUG 2 - 1955
BIRTH NO. **62392-55** 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 Missouri b. COUNTY		
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. LENGTH OF STAY (In this place) 7 hrs 51 min	c. CITY (If outside corporate limits, write RURAL and give township) St. Louis		2219 10
d. FULL NAME OF HOSPITAL OR INSTITUTION Romer G. Phillips			d. STREET ADDRESS (If rural, give location) 21 3038 Dickson		
3. NAME OF DECEASED (Type or Print) a. (First) Rita		b. (Middle) (Twin # 1)	c. (Last) Auberry	4. DATE OF DEATH (Month) (Day) (Year) 6 15 55	
5. SEX Fem. 3	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH 6-15-55	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months Days
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) Missouri		12. CITIZEN OF WHAT COUNTRY? 0	
13a. FATHER'S NAME Samuel Auberry		13b. MOTHER'S MAIDEN NAME Hattie Love		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 Katherine M. Howard CRL 2601 N. Whittier			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Premature birth, neonatal death				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) 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 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) 7735			
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?			
22. I hereby certify that I attended the deceased from 6-15- , 1955, to 6-15- , 1955, that I last saw the deceased alive on 6-15- , 1955, and that death occurred at 10:20 a. m. , from the causes and on the date stated above.					
23a. SIGNATURE William H. Sautter M. D.		23b. ADDRESS 2601 N. Whittier		23c. DATE SIGNED 6-22-55	
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 7-30-55	24c. NAME OF CEMETERY OR CREMATORY Anatomical Board	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.		
DATE REC'D BY LOCAL REG. JUL 19 1955	REGISTRAR'S SIGNATURE Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Rowland-Aker Mortuary Service 4104 Manchester Ave. St. Louis 10, 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
Student Embalmer

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 this body is not embalmed, fact should be so stated above.