

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **7392**
1642
Registrar's No.FILED MAR 5 1956
BIRTH NO. **3889-56** 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) OR TOWN ST. LOUIS, MISSOURI | | c. LENGTH OF STAY (in this place) | | c. CITY OR TOWN St. Louis | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSPITAL #1. | | e. STREET ADDRESS (If rural, give location) 4134 PAPIN | | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or Print) BABY GIRL | | a. (First) | | b. (Middle) WHITESIDE | |
| c. (Last) | | 4. DATE OF DEATH (Month) (Day) (Year) JANUARY 8, 1956 | | | |
| 5. SEX FEMALE | | 6. COLOR OR RACE NEGRO | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Infant | |
| 8. DATE OF BIRTH JAN. 8, 1956 | | 9. AGE (In years last birthday) Months Days | | IF UNDER 1 YEAR Days Hours Min. 2 30 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13a. FATHER'S NAME SAMUEL Whiteside | | 13b. MOTHER'S MAIDEN NAME ROSLYN HUNTER | |
| 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 Roslyn Whiteside | | ADDRESS 4134 Papin St. | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prematurity | | | INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hours |
| *This does not mean the mode of dying, such as heart failure, asthenia, 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) _____ 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) 776x | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | | 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 1-8 , 1956, to 1-8 , 1956, that I last saw the deceased alive on 1-8 , 1956, and that death occurred at 5:15 A.M. , from the causes and on the date stated above. | | | | | |
| 23a. SIGNATURE Don B. Klink M.D. | | (Degree or title) | | 23b. ADDRESS 1515 LAFAYETTE AVE. | |
| 23c. DATE SIGNED 1-9-56. | | 24a. BURIAL, CREMATION, REMOVAL (Specify) | | 24b. DATE 2-29-56 | |
| 24c. NAME OF CEMETERY OR CREMATORY Anatomical Board | | 24d. LOCATION (City, town, or county) (State) St. Louis, Mo. | | | |
| DATE REC'D BY LOCAL REG. FEB 16 1956 | | REGISTRAR'S SIGNATURE Paul Smith MD | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Rowland-Aker Mortuary Service 4104 Manchester Ave. St. Louis 10, Mo. | |

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.....

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.