

FILED FEB 27 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

7531

State File No.

BIRTH NO. 11865-56 REG. DIST. NO. 312 PRIMARY REG. DIST. NO. 541 Registrar's No. 369

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Clayton</u>	c. LENGTH OF STAY (in this place) <u>2 hrs.</u>	c. CITY OR TOWN <u>Clayton</u> <u>4454</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. Louis County Hospital</u>		e. STREET ADDRESS (If rural, give location) <u>7710 Bonhomme</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Baby Boy</u> b. (Middle) <u>Wilkinson</u> c. (Last) <u>Wilkinson</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>2 1 56</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never Married</u>	8. DATE OF BIRTH <u>Feb. 1, 1956</u>	9. AGE (In years last birthday) <u>2</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u>	IF UNDER 24 HRS. Hours <u>2</u> Min.
10a. USUAL OCCUPATION (Of the kind of work done during most of working life, even if retired) <u>Child</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis Co., Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			

13a. FATHER'S NAME <u>Gale Wilkinson</u>	13b. MOTHER'S MAIDEN NAME <u>Anita M. Cain</u>	14. NAME OF HUSBAND OR WIFE <u>None</u>
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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>St. Louis Co. Hosp - Clayton, Mo</u>	ADDRESS
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral anoxia</u>		<u>2 hrs</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		
DUE TO (b) <u>Immature development of lungs & brain</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 <u>7590</u> <u>7625</u>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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)	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 2-1, 1956, to 2-1, 1956, that I last saw the deceased alive on 2-1, 1956, and that death occurred at 9:15A. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Robert P. Blombe MD</u>	23b. ADDRESS <u>433 Belvedere Lane St. Louis 19, Mo</u>	23c. DATE SIGNED <u>2/2/56</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	24b. DATE <u>2-8-56</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Missouri Crematory</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis Mo.</u>
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DATE REC'D BY LOCAL REG. <u>2-8-56</u>	REGISTRAR'S SIGNATURE <u>Herbert R. Blombe MD</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>St. Louis Co. Hosp - Clayton, Mo.</u>	ADDRESS
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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

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.**