

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25251
STATE FILE NUMBER
6062

42501-56
FILED JUL 20 1956

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

30
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		c. CITY OR TOWN ST. LOUIS, MISSOURI		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSPITAL #1		Length of stay in 1b		d. STREET ADDRESS 24 3611 SO. BDWY.	
3. NAME OF DECEASED (Type or print) First MIDDLE Last BABY BOY SHERBOURNE		4. DATE OF DEATH Month Day Year JUNE 9, 1956			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 4, 1956	9. AGE (In years last birthday) 0	IF UNDER 1 YEAR Months Days 0 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (City and state or country) ST. LOUIS, MISSOURI	
13. FATHER'S NAME DARWIN SHERBOURNE		14. MOTHER'S MAIDEN NAME VIRGINIA MOORE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address ST. LOUIS CITY HOSPITAL RECORD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity DUE TO (b) Congenital Atelectasis DUE TO (c) Subdural Hematoma (Subtentorial) PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 7605					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 7605			
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 6/4/56 to 6/5/56 and last saw her alive on 6/5/56 Death occurred at 2:35 AM on the deceased above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>Paul Smith MD</i>		22b. ADDRESS 1515 LAFAYETTE AVE.		22c. DATE SIGNED 6/5/56.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 6-30-56		23c. NAME OF CEMETERY OR CREMATORY Anatomical Board	
23d. LOCATION (City, town, or county) St. Louis, Mo.		23e. (State)			
24. FUNERAL DIRECTOR Rowland Aker Mortuary Service		ADDRESS		25. DATE RECD. BY LOCAL REG. JUN 27 1956	
				26. REGISTRAR'S SIGNATURE <i>Paul Smith MD</i>	

1104 Manchester Ave.
St. Louis 10, Mo.

(Licensed Embalmer's Statement on Reverse Side)

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.