

FILED APR 15 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

318

1003

STATE FILE NUMBER

2988

17340-57

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

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		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN ST. LOUIS		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 25 ST. LOUIS CITY HOSP. #1			Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 2229 MISSISSIPPI	
3. NAME OF DECEASED (Type or print) First MIDDLE Last CHARLENE THOMASENE ADAIR			4. DATE OF DEATH Month Day Year MAR. 16, 1957		
5. SEX GIRL	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 2/27/57	9. AGE (In years last birthday) 16	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) no		10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (City and state or country) ST. LOUIS CITY HOSP. #1		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME THOMAS HEELIN ADAIR			14. MOTHER'S MAIDEN NAME RUBY MAE JONES		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) (If unknown, or dates of service) NO NONE		16. SOCIAL SECURITY NO. NONE	17. INFORMANT Address ST. LOUIS CITY HOSP. #1		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE-(a) <i>bilateral bronchopneumonia</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 7630					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.)		
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.					
20d. INJURY OCCURRED WHILE AT <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 Death occurred at <u>11:55 A.M.</u> on <u>2/27/57</u> to <u>3/15/57</u> and last saw her/him alive on <u>3/15/57</u> . Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <i>Ronald A. Severa, M.D.</i>			22b. ADDRESS 1515 LAFAYETTE AVE.		22c. DATE SIGNED 3/15/57.
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 3-30-57	23c. NAME OF CEMETERY OR CREMATORY Anatomical Board		23d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
24. FUNERAL DIRECTOR <i>Ronald - aka 404 Mendenhall</i>		ADDRESS	25. DATE RECD. BY LOCAL REG. MAR 28 57	26. REGISTRAR'S SIGNATURE <i>Paul Smith MD</i> m & b.	

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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 emb

by me, or by ..... Student Embalmer No.....

working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed.....

Licensed Embalmer No.....

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P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F  
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.