

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33393

STATE FILE NUMBER 8777

FILED SEP 26 1957

Registration District No. 318 Primary Registration District No. 1003

Registrar's No. 8777

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo</i> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO.		c. CITY OR TOWN ST. LOUIS, MO.	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. #1.		d. STREET ADDRESS (If outside, give location) 1313 SO. 8th st.	
3. NAME OF DECEASED (Type or print) BABY BOY		4. DATE OF DEATH Month SEPT. Day 15th Year 1957	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/14/57
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during working life, even if retired) NONE	11. BIRTHPLACE (City and state or country) ST. LOUIS, MO.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JAMES DAVIS	
13b. MOTHER'S MAIDEN NAME VIOLA THOMPSON		14. NAME OF HUSBAND OR WIFE NO	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT 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>Respiratory insufficiency</i> DUE TO (b) <i>Prematurity</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART-I (a)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		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.) 773.5	
20c. TIME OF INJURY Hour 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 9/14/57 to 9/15/57 and last saw her alive on 9/15/57 Death occurred at 8:18 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) <i>Langin C. Curran M.D.</i>	
22b. ADDRESS 1515 LAFAYETTE AVE.		22c. DATE SIGNED 9/17/57	
23a. BURIAL, CREMATION, REMOVAL (Specify) 9-30 57		23b. DATE	
23c. NAME OF CEMETERY OR CREMATORY Anatomical Board		23d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
24. FUNERAL DIRECTOR Kawland Aker 4104 Manchester		25. DATE RECD. BY LOCAL REG. SEP 19 57	
26. REGISTRAR'S SIGNATURE <i>Carl Smith Mo</i>		27. (Licensed Embalmer's Statement on Reverse Side)	

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

2788

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.