

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED DEC 10 1957

318

1003

41815
STATE FILE NUMBER

11652
Registrar's No.

Registration District No. _____ Primary Registration District No. _____

V. S. 300
Rev. 1-57

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jefferson		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Kimmswick		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Anthonys Hospital		Length of stay in lb 2 hrs.	d. STREET ADDRESS 29		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First John Middle David Last Cagle			4. DATE OF DEATH Month Dec. Day 1, Year 1957		
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 Dec. 1, 1957	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HRS. Hours 2 Min. Hrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Ray Cagle		13b. MOTHER'S MAIDEN NAME Patricia Bradley		14. NAME OF HUSBAND OR WIFE None	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Address Ray Cagle, Kimmswick, Mo.		
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>Anomalous distribution of pulmonary arteries</i> DUE TO (b) <i>Abrial septal deficiency</i> DUE TO (c) <i>Bilateral kidney agenesis</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs</i> <i>2 hrs</i> <i>2 hrs</i>
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.) 754.3			
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 12-7-57 to 12-7-57 and last saw ^{her} him alive on 12-7-57 Death occurred at 12-7-57 8:35 P m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <i>John D. Smith</i>			22b. ADDRESS 3739 Brarris		22c. DATE SIGNED 12-3-57
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 12-2-57	23c. NAME OF CEMETERY OR CREMATORY Leadwood Cemetery		23d. LOCATION (City, town, or county) (State) Leadwood, Mo.
24. FUNERAL DIRECTOR Albert H. Hoppe 4700 Washington, Blvd.			25. DATE RECD. BY LOCAL REG. DEC 4 57		26. REGISTRAR'S SIGNATURE <i>Carl Smith</i> msc

securing the medical certification in the specific manner required by 193.140 MoRS 1949.
 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

