

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED NOV 22 1957

41907

STATE FILE NUMBER
10034

Registration District No. 318

Primary Registration District No. 1003

Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St Louis		c. CITY OR TOWN St Louis 15 4/10	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 30 Saint Louis Maternity		d. STREET ADDRESS (If outside, give location) 27 10625 Glen Garry Road	

3. NAME OF DECEASED (Type or print) First Middle Last Dill			4. DATE OF DEATH Month Day Year October 25 1957		
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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 October 25 1957	9. AGE (In years last birthday) UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min 1 35
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) St Louis Missouri	12. CITIZEN OF WHAT COUNTRY? --
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13a. FATHER'S NAME Robert A Dill	13b. MOTHER'S MAIDEN NAME Joy Elinor Moeller	14. NAME OF HUSBAND OR WIFE --
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. --	17. INFORMANT Joy Elinor Dill Address above
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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) Maternal abnormality. Bicornuate uterus. DUE TO (c) 776x		INTERVAL BETWEEN ONSET AND DEATH 1 hr 35 min
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Agenesis of left diaphragm & herniation of abdom. viscera into left chest		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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.)
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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
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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
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21. I attended the deceased from Death occurred at 12:45 P M	October 25 1967 to October 25 1957 and last saw her alive on October 25 1957	on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) Frederick A Peterson, MD	22b. ADDRESS 500 So Kingshighway, St. Louis	22c. DATE SIGNED Oct 26, 1957
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 10/26/57	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	23d. LOCATION (City, town, or country) (State) St. Louis, County, Missouri
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24. GENERAL REGISTRY ADDRESS CALVIN F. FEUTZ, 4828 Natural Bridge Blvd., FUNERAL HOME, St. Louis, 15, Missouri	25. DATE RECD. BY LOCAL REG. OCT 26 57	26. REGISTRAR'S SIGNATURE Carl Smith - MD
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

Securing the medical certificate in time - specific manner required by Province of Ontario.

Baby is premature & only one hour & thirty minutes old & being buried within 24 hours

Calvin Freutz Funeral

John Keyser

NOT EMBALMED.

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.