

THE DIVISION OF HEALTH OF MISSOURI 18181-58
STANDARD CERTIFICATE OF DEATH

58-011309
State File No.
Registrar's No. 2854

FILED MAR 19 1958

318

1003

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____

1. PLACE OF DEATH
a. COUNTY _____

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri b. COUNTY _____

b. CITY (If outside corporate limits, write RURAL and give township) St. Louis

c. CITY OR TOWN St. Louis

d. Is Residence within limits of a city or incorporated town? Yes No

d. FULL NAME OF HOSPITAL OR INSTITUTION FIRMIN DESLOGE Hospital

STREET ADDRESS (If rural, give location) 5911A Lotus

3. NAME OF DECEASED
a. (First) _____ b. (Middle) _____ c. (Last) BANKS

4. DATE OF DEATH (Month) (Day) (Year) 3 9 1958

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married

8. DATE OF BIRTH 3-9-1958

9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. 30

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 Foreign Country) St. Louis, Missouri

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME EVERETT HENRY BANKS

13b. MOTHER'S, MAIDEN NAME JUNE LOU LLA TETJEN

14. NAME OF HUSBAND OR WIFE _____

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No

16. SOCIAL SECURITY NO. None

17. INFORMANT'S SIGNATURE OR NAME ADDRESS Everett Banks, 5911a Lotus Ave.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)
MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Anencephaly
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) 750x
DUE TO (c) _____
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION _____

19b. MAJOR FINDINGS OF OPERATION _____

20. AUTOPSY? 2
YES NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____

21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from March 9, 1958, to March 9, 1958, that I last saw the deceased alive on March 9, 1958, and that death occurred at 9:35A, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Ralph C. Schwanz M.D.

23b. ADDRESS 9141 North Swan Cr.

23c. DATE SIGNED 3-10-58

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal

24b. DATE 3-11-58

24c. NAME OF CEMETERY OR CREMATORY St. Trinity Cem.

24d. LOCATION (City, town, or county) (State) St. Louis Co., Missouri

DATE REC'D BY LOCAL REG. MAR 11 1958 REGISTRAR'S SIGNATURE Carl Smith MD

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS McLAUGHLIN'S, 2301 Lafayette

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed ^{not}

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

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *James R. Chapman*

Licensed Embalmer No... *455*

P. O. Address *A. L. Davis*

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.