Health, & Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI 60882-58

STANDARD CERTIFICATE OF DEATH

58-031225
STATE FILE NUMBER

FILED AUG 18 1958 Registration District No. 317 Primary Registration District No. 541 Registrar's No. 2073

1. PLACE OF DEATH
a. COUNTY ST. LOUIS
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) Clayton — Inside Limits Yes ☒ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) COUNTY HOSPITAL — Length of stay in 1b 2 DAYS

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY St. Louis
c. CITY OR TOWN Olivette 4000 — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 1348 Dielman Rd. — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First Middle Last: BABY GIRL SHEPARD
4. DATE OF DEATH Month Day Year: 7 26 1958

5. SEX: Female 3
6. COLOR OR RACE: Colored
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 7-24-58
9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days 2 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE
10b. KIND OF BUSINESS OR INDUSTRY: NONE
11. BIRTHPLACE (City and state or country): Clayton, Mo.
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME: Unknown
13b. MOTHER'S MAIDEN NAME: Ethel Shepard
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)
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT Address: St. Louis County Hospital

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ATALECTASIS NEONATORUM — INTERVAL BETWEEN ONSET AND DEATH 50 hrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)
DUE TO (c) 7620
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 ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 7-24-1958, to 7-26-1958 and last saw her/him alive on 7-26-1958
Death occurred at 4:00 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Levi Gowen MD.
22b. ADDRESS: 601 S. BRENTWOOD.
22c. DATE SIGNED: 7-28-58

23a. BURIAL, CREMATION, REMOVAL (Specify): CREMATION
23b. DATE
23c. NAME OF CEMETERY OR CREMATORY: Mo. CREMATORY
23d. LOCATION (City, town, or county) (State): ST LOUIS MO

24. FUNERAL DIRECTOR: COUNTY HOSPITAL — ADDRESS: CLAYTON, MO
25. DATE RECD. BY LOCAL REG.: 8-8-58
26. REGISTRAR'S SIGNATURE: Herbert R. Domke M.D.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.

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 ..... Signed .....
Signature of Student Embalmer

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.