

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED OCT 10 1958

58-034079
STATE FILE NUMBER

318

1003

9419
Registrar's No.

Registration District No. _____ Primary Registration District No. _____

5. 300
1-57

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, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 27 Homer G. Phillips		Length of stay in lb		d. STREET ADDRESS (If outside, give location) 2067 5070A Minerva	
3. NAME OF DECEASED (Type or print) First Middle Last Cheryl Carter			4. DATE OF DEATH Month Day Year 9 29 58		
5. SEX Fem. 3	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 9-29-58	9. AGE (In years last birthday) 3	IF UNDER 1 YEAR Months Days 4 9
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) Saint Louis, Missouri	12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME Catherine Carter		14. NAME OF HUSBAND OR WIFE	
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.	17. INFORMANT Hospital Records, 2601 N. Whittier		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Premature birth, Neonatal death					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					773.5
DUE TO (b) _____					
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"/>
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.)		
20c. TIME OF INJURY Hour Month, Day, Year 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 9-29-58 to 9-29-58 and last saw her her alive on 9-29-58 Death occurred at 9:10 A. m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE Earl Smith (Degree or title) M. D.			22b. ADDRESS 2601 N. Whittier		22c. DATE SIGNED 9-30-58
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 10 31-58	23c. NAME OF CEMETERY OR CREMATORY Anatomical Board		23d. LOCATION (City, town, or county) (State) St. Louis, Mo.
24. FUNERAL DIRECTOR Rowland Allen		ADDRESS 4104 Manchester		25. DATE RECD. BY LOCAL REG. OCT 2 '58	26. REGISTRAR'S SIGNATURE Earl Smith mjb.

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

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.

