

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-034746

STATE FILE NUMBER

69702-58
FILED SEP 25 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

8945

300
1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO.		c. CITY OR TOWN ST. LOUIS, MO.	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. #1.		d. STREET ADDRESS : (If outside, give location) 2209 1505 N. JEFFERSON	
3. NAME OF DECEASED (Type or print) First Middle Last BABY BOY SYKES		4. DATE OF DEATH Month Day Year Aug. 12 1958	
5. SEX MALE 2	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 ✓ 8/12/58
9. AGE (In years last birthday)		10. FUNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hour 5 Min 45
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) ST. LOUIS, MO.
12. CITIZEN OF WHAT COUNTRY? U.S.A		13a. FATHER'S NAME UNKNOWN	
13b. MOTHER'S MAIDEN NAME IRENE SYKES		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, NO known) (If yes, give NO dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT ST. LOUIS CITY HOSP. #1.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anoxia</u> DUE TO (b) <u>immaturity</u> DUE TO (c) <u>762.5</u> 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
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 <u>8/12/58</u> to <u>8/12/58</u> and last saw <input checked="" type="checkbox"/> him alive on <u>8/12/58</u> Death occurred at <u>8:15 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Do V. Mullen, M.D.</u>		22b. ADDRESS <u>1515 Lafayette Ave.</u>	
22c. DATE SIGNED <u>8/13/58</u>		23a. BURIAL, CREMATION, REMOVAL (Specify)	
23b. DATE <u>9-30-58</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Anatomical Board</u>	
23d. LOCATION (City, town, or county) <u>St. Louis, Mo.</u>		(State)	
24. FUNERAL DIRECTOR <u>Rowland Akew 404 Manchester</u>		25. DATE RECD. BY LOCAL REG. <u>SEP 17 '58</u>	
26. REGISTRAR'S SIGNATURE <u>Cash Smith, Mo</u>			

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.