

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-042416

STATE FILE NUMBER

10632

FILED NOV 20 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

300
-57

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO.			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	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.			Length of stay in lb #1.	d. STREET ADDRESS 5188 PAGE (If outside, give location)	
3. NAME OF DECEASED (Type or print) First BABY GIRL Middle WELLINGTON Last P.			4. DATE OF DEATH Month OCT. Day 29 Year 1958		
5. SEX FEMALE	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 10/29/58	9. AGE (In years last birthday) 0	IF UNDER 1 YEAR Months 0 Days 0 Hours 30 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) no		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 MARTHA WELLINGTON		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no unknown) (If yes, give war or no of service)		16. SOCIAL SECURITY NO. no	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) Congenital Atelectasis Conditions, if any, which gave rise to above cause (a), starting the underlying cause last. } DUE TO (b) Immaturity DUE TO (c) 762.5					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 p.m. Month, Day, Year					
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
21. I attended the deceased from 10/29/58 to 10/29/58 and last saw ^{her} him alive on 10/29/58 Death occurred at 6:45 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE James F. McCool M.D. (Degree or title)			22b. ADDRESS 1515 LAFAYETTE AVE		22c. DATE SIGNED 10/29/58
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 11-29-58	23c. NAME OF CEMETERY OR CREMATORY Anatomical Board		23d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
24. FUNERAL DIRECTOR Rawland Aku 4104 Mandeville		ADDRESS	25. DATE RECD. BY LOCAL REG. NOV 6 '58	26. REGISTRAR'S SIGNATURE James F. McCool M.D.	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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
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.