Health, Welfare Public Service

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1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-014936
STATE FILE NUMBER
2 3982

FILED MAY 6 1959 Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

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 — Inside Limits Yes ☐ No ☐	c. CITY OR TOWN ST.LOUIS,MO. — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) ST. LOUIS CITY HOSPITAL#1. — Length of stay in 1b	d. STREET ADDRESS 2209 DIVISION (Rural, give location) ST.LOUIS,MO. — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First (BABY BOY) Middle DERRICK Last EBERHART			4. DATE OF DEATH Month 4 Day 12 Year 1959	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH 4/12/59	9. AGE (In years last birthday) — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours 9 Min. 29
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, MISSOURI	12. CITIZEN OF WHAT COUNTRY? u.s.a	
13a. FATHER'S NAME DOUGLAS EBERHART	13b. MOTHER'S MAIDEN NAME ETOY RAY	14. NAME OF HUSBAND OR WIFE		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT ST.LOUIS CITY HOSP, #1.	Address	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Atelectasis

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Prematurity

DUE TO (c) 762.5

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 4-12-1959, to 4-12-1959 and last saw her/him alive on 4-12-1959

Death occurred at 2:50 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Michael S Possgay, MD (Degree or title)	22b. ADDRESS 1515 LAFAYETTE AVE.	22c. DATE SIGNED 4-12-1959
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 4-30-59	23c. NAME OF CEMETERY OR CREMATORY Anatomical Board
23d. LOCATION (City, town, or county) St. Louis, Mo. (State)		
24. FUNERAL DIRECTOR Rowland Aker — ADDRESS 4104 Manchester	25. DATE RECD. BY LOCAL REG. APR 23 '59	26. REGISTRAR'S SIGNATURE Earl Smith, M.D. MJC

(Licensed Embalmer's Statement on Reverse Side)

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.