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THE DIVISION OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

59-019091
STATE FILE NUMBER
2 4495

FILED MAY 18 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 Mo. b. COUNTY

b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) St. Louis — Inside Limits Yes ☐ No ☐

c. CITY OR TOWN St. Louis — Inside Limits Yes ☐ No ☐

c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Incarnate Word Hospt. — Length of stay in 1b

d. STREET ADDRESS (If outside, give location) 1443 Benton St. — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First: Robert Middle: Allen Last: Davis

4. DATE OF DEATH Month: 5 Day: 6 Year: 59

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 30 1959

9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days: 8 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant

10b. KIND OF BUSINESS OR INDUSTRY: ------

11. BIRTHPLACE (City and state or country): St. Louis

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME: Donald Davis

13b. MOTHER'S MAIDEN NAME: Gloria Hampton

14. NAME OF HUSBAND OR WIFE: None

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service) ----

16. SOCIAL SECURITY NO.: None

17. INFORMANT Address: Donald Davis 1443 Benton St.

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) Congenital Heart Defect — INTERVAL BETWEEN ONSET AND DEATH: 1 week

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

DUE TO (b) Multiple Congenital Anomalies

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Syndactilism - 754.5

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: St. Louis — COUNTY — STATE: Mo.

21. I attended the deceased from Birth, to 5-6-59 and last saw ~~him~~ bim alive on 5-6-59.
Death occurred at 5 04 P.m. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): [signature] Egg-Dreen M.D.

22b. ADDRESS: 1927 a Union

22c. DATE SIGNED: 5-7-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 5/7/59

23c. NAME OF CEMETERY OR CREMATORY: Lakewood Park Cemetery

23d. LOCATION (City, town, or county) (State): St. Louis Mo.

24. FUNERAL DIRECTOR ADDRESS: Robert D. Kinealy 2228 St.LouisAve.

25. DATE RECD. BY LOCAL REG.: MAY 7 '59

26. REGISTRAR'S SIGNATURE: Earl Smith, M.D. S.P.

(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 .....
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.