

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-023539

STATE FILE NUMBER
25542

FILED JUN 24 1959

36
300
1-57

61

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON. TYPE WRITE IF POSSIBLE.

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, Missouri		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis Children's Hospital		Length of stay in lb Not admitted	d. STREET ADDRESS (If outside, give location) 1451 Chambers Street Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Carol Nancy Willis			4. DATE OF DEATH Month Day Year 6 - 9 - 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-10-47
9. AGE (In years last birthday) 12 yrs		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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
13a. FATHER'S NAME Frank n.m.n. Willis		13b. MOTHER'S MAIDEN NAME Lola Luchini	14. NAME OF HUSBAND OR WIFE Single
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Alice Trowbridge, 500 S. Kingshighway 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) Labor pneumonia DUE TO (b) unidentified organism DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Severe cerebral palsy following TB meningitis 1949			INTERVAL BETWEEN ONSET AND DEATH ? several weeks
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.) 490 X A	
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 6-9-59 , to and last saw her alive on 6-9-59 Death occurred at 12.30 a. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Richard H. Spivey, M.D.		22b. ADDRESS 500 S. Kingshighway	22c. DATE SIGNED 6-9-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE June 12-59	23c. NAME OF CEMETERY OR CREMATORY Memorial Pk. Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.,
24. FUNERAL DIRECTOR Leidner Und. Co. 2223 St. Louis Ave.		25. DATE RECD. BY LOCAL REG. JUN 10 '59	26. REGISTRAR'S SIGNATURE Roan Smith, M.D.

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 *Albert Maggello*

Licensed Embalmer No. *3077*

P. O. Address *Lawist*

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.