

FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS APR 12 1960

310

Registration District No.

3058

Primary Registration District No.

79

Registrar's No.

60-012229

STATE FILE NUMBER

UNRECORDED

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY ST. CHARLES	b. CITY (If outside corporate limits, give TOWNSHIP only) ST. CHARLES	a. STATE Missouri	b. COUNTY St Louis
Length of stay in lb 2 hrs		c. CITY OR TOWN Bridgeton	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF HOSPITAL OR INSTITUTION ST. JOSEPH'S HOSPITAL		d. STREET ADDRESS 3675 Welland	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First CHERYL	Middle LYNN	Last WILLOUGHBY	4. DATE OF DEATH	Month 4	Day 8	Year 60
-------------------------------------	------------------------	-----------------------	---------------------------	------------------	-------------------	-----------------	-------------------

5. SEX FEMALE	6. COLOR OR RACE WH	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4-5-60	9. AGE (last birthday)	IF UNDER 1 YEAR Months 2 Days 22 Hours 32	IF UNDER 24 HR Hours 22 Min. 32
-------------------------	-------------------------------	--	-----------------------------------	------------------------	---	--

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. Charles Mo. U.S.A.	12. CITIZEN OF WHAT COUNTRY U.S.A.
--	--	---	--

13a. FATHER'S NAME JAKE FREDERICK	13b. MOTHER'S MAIDEN NAME KINKEAD	14. NAME OF HUSBAND OR WIFE None
---	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. None	17. INFORMANT Jake Willoughby, Belle Mo	Address Belle Mo
---	--	---	----------------------------

18. CAUSE OF DEATH (Enter only one cause of life for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH 3 days
IMMEDIATE CAUSE (a) Atelectasis	DUE TO (b) Premature Birth	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
---	--

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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 a.m. 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 Belle Mo	COUNTY Belle Mo	STATE Mo
--	--	---	---------------------------	--------------------

21. I attended the deceased from **4-5-60** to **4-8-60** and last saw her alive on **4-8-60**
Death occurred at **8 A.m** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE W. J. Turner M.D.	(Degree or title)	22b. ADDRESS 1441 Main St. Charles Mo	22c. DATE SIGNED 4-8-60
--	-------------------	---	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE April 8, 1960	23c. NAME OF CEMETERY OR CREMATORY Liberty Cemetery	23d. LOCATION (City, town, or county) Belle Mo
---	-----------------------------------	---	--

24. FUNERAL DIRECTOR J.C. Dallmeyer & Sons Co., St. Charles Mo	ADDRESS	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE Marcelle Wilson
--	---------	------------------------------	---

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Note: Body not embalmed

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.