

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS APR 4 1960

60-013224

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STATE FILE NUMBER

Registration District No. Primary Registration District No. Registrar's No.

1. PLACE OF DEATH a. COUNTY 13 yrs.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo.	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Chronic Hosp.		d. STREET ADDRESS 5800 Arsenal St.	

3. NAME OF DECEASED (Type or print) First Amy	Middle	Last Singleton	4. DATE OF DEATH Month 3-25-60	Day 25	Year 60
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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 6-2-1920	9. AGE (last birthday) 39	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Never employed	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) New Jersey	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Michael Singleton	13b. MOTHER'S MAIDEN NAME Amy Van Hauten	14. NAME OF HUSBAND OR WIFE
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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.	17. INFORMANT Marguerite Stricker	Address 409 S. Leclade Station
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Microcephaly + Congenital Hypoplasia		INTERVAL BETWEEN ONSET AND DEATH life.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		753.1
PART III. If deceased was female was there a pregnancy in last 90 days.		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)
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20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year
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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
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21. I attended the deceased from **4-16-46** to **3-25-60** and last saw her alive on **3-25-60**
Death occurred at **8:00 a.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE John W. Beckham, M.D.	(Degree or title)	22b. ADDRESS 5800 Arsenal	22c. DATE SIGNED 3/25/60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 3-26-1960	23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery	23d. LOCATION (City, town, or county) Kirkwood, Mo.
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24. FUNERAL DIRECTOR Hoffmeister Colonial Mortuary	ADDRESS 6464 Chippewa St. St. Louis, Mo.	25. RECEIVED BY LOCAL REG. MAR 25 1960	26. REGISTRAR'S SIGNATURE Roan Smith, M.D.
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

410

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Bill C. Branson

Licensed Embalmer No. 4964

P. O. Address St Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.