URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS APR 22 1960

-60-016863

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 4074

NDED

1. PLACE OF DEATH
a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St Louis Mo

Length of stay in 1b

c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): 2838 Laclede

Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo
b. COUNTY

c. CITY OR TOWN: St Louis

Inside Limits: Yes ☐ No ☐

d. STREET ADDRESS (If outside, give location): 2838 Laclede

Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Baby Middle: Gray Last:

4. DATE OF DEATH: Month 3 Day 15 Year 60

5. SEX: Fem

6. COLOR OR RACE: Negro

7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 2-9-60

9. AGE (last birthday)

IF UNDER 1 YEAR: Months 1 Days

IF UNDER 24 HR: 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): Mo

12. CITIZEN OF WHAT COUNTRY: USA

13a. FATHER'S NAME: Unk

13b. MOTHER'S MAIDEN NAME: Unk

14. NAME OF HUSBAND OR WIFE: Unk

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

16. SOCIAL SECURITY NO.: None

17. INFORMANT: E. C. Joyce Address: 1300 Clark

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Suffocation when found in

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

DUE TO (b): Well in home on or about

DUE TO (c): March 15 1960

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 924.0 18

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

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.): Suffocation

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year: 3 4 60

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.): Home

20f. CITY, TOWN, OR LOCATION: St Louis COUNTY STATE: Mo

21. I attended the deceased from _____, to _____ and last saw her/him alive on _____

Death occurred at 5:45 m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): [signature] Deputy Coron

22b. ADDRESS: 1300 Clark

22c. DATE SIGNED: 3-25-60

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE: 4-30-60

23c. NAME OF CEMETERY OR CREMATORY: Anatomical Board

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

24. FUNERAL DIRECTOR: Rowland Mortuary Svc. ADDRESS: 4104-06 Manchester

25. DATE RECD. BY LOCAL REG.: APR 14 1960

26. REGISTRAR'S SIGNATURE: Carl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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_____ 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 con
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.