

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-021864

FILED VS JUN 6 1960

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 1628

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MA</u> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Richmond Heights</u>		Length of stay in 1b <u>12 MIN.</u>		c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Mary's</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>1129 Louisville Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>BABY</u> Middle <u>Montikew</u> Last <u>Mo</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>22</u> Year <u>60</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>5/22/60</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		9. AGE (last birthday) <u>-</u>		IF UNDER 1 YEAR Months Days Hours Min. <u>12</u>	
11. BIRTHPLACE (City and state or country) <u>Richmond Hts, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>					
13a. FATHER'S NAME <u>Ralph Montikew</u>			13b. MOTHER'S MAIDEN NAME <u>Joan Kaiser</u>			14. NAME OF HUSBAND OR WIFE <u>NONE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>Ralph Montikew 1129 Louisville</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Premature Birth 27 weeks</u> DUE TO (b) <u>Marginal placental separation</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							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)					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 COUNTY STATE	
21. I attended the deceased from <u>5/22/60</u> to <u>5/22/60</u> and last saw her/him alive on <u>5/22/60</u> Death occurred at <u>2:30 p.m.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>L.M. Riordan MD</u> (Degree or title)				22b. ADDRESS <u>4500 Olive St</u>			22c. DATE SIGNED <u>5/23/60</u> (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>5/23/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Galvary Ceme</u>		23d. LOCATION (City, town, or county) <u>St. Louis Mo</u> (State)		
FURNAL DIRECTOR ADDRESS <u>Calvin F Feutz 4828 Natl Dridge</u>		25. DATE RECD. BY LOCAL REG. <u>5-23-60</u>		26. REGISTRAR'S SIGNATURE <u>John B. Murphy MD</u>			

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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed not embalmed

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.