

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Nevada b. COUNTY Clark	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 12 days	c. CITY OR TOWN North Las Vegas
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis Children's		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2250 Daley St.

3. NAME OF DECEASED (Type or print) First Middle Last Cynthia Chiryl Derickson			4. DATE OF DEATH Month Day Year 11 25 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 7-9-60	9. AGE (last birthday) 4 1/2	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) none	10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (City and state or country) Las Vegas Nevada	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME Robert Derickson	13b. MOTHER'S MAIDEN NAME Shirley Glatt	14. NAME OF HUSBAND OR WIFE none
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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. none	17. INFORMANT Mary Ritter 500 S Kingshighway	Address
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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) <u>Cardiac arrest</u> DUE TO (b) <u>bronchopneumonia</u> DUE TO (c) <u>Post-op for congenital rectal structure.</u>		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) 756.1		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 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 Month, Day, Year a.m. p.m.	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 <u>11-13-60</u> to <u>11-25-60</u> and last saw her/him alive on <u>11-25-60</u> Death occurred at <u>7:15 a</u> m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Eugenia M. Paine, M.D.</u>	22b. ADDRESS <u>Childrens Hospital</u>	22c. DATE SIGNED <u>NOV 28 1960</u>
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23a. BURIAL, CREMATION, OR REMOVAL (Specify) Removal	23b. DATE 11/26/60	23c. NAME OF CEMETERY OR CREMATORY Imperial, Missouri.	23d. LOCATION (City, town, or county) Imperial, Missouri.
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24. FUNERAL DIRECTOR Heiligtag Funeral Home, Imperial, Missouri.	25. DATE RECD. BY LOCAL REG. NOV 28 1960	26. REGISTRAR'S SIGNATURE <u>Loan Smith, M.D.</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MAR 7 1961

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 Olmo R. Padua

Licensed Embalmer No. 4077

P. O. Address St Louis

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.