

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. ¹ institution: Residence before admission)		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St Louis			c. CITY OR TOWN Clayton		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St John,s Hospital			d. STREET ADDRESS (If outside, give location) 10 S Lyle Ave		
3. NAME OF DECEASED (Type or print) Infant			4. DATE OF DEATH Nov 10 1960		
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 11/10/60		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			11. BIRTHPLACE (City and state or country) St Louis Mo		
13a. FATHER'S NAME Frank Sindelar			14. NAME OF HUSBAND OR WIFE None		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			17. INFORMANT Frank Sindelar		
16. SOCIAL SECURITY NO. No			Address Clayton 5 10 S Lyle Ave		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Erythroblastosis Fetalis		INTERVAL BETWEEN ONSET AND DEATH Lite
DUE TO (b) Rh incompatibility		
DUE TO (c) 770.0		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e)		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.)	
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 Birth to 1:25 p.m. 11-10-60		and last saw her/him alive on 11-10-60	
Death occurred at 1:25 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE <i>Francis X. Pich</i>	(Degree or title)	22b. ADDRESS 674 N. Grand	22c. DATE SIGNED 11-12-60
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 11/14/60	23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery	23d. LOCATION (City, town, or county) St Louis County Missouri
24. FUNERAL DIRECTOR	ADDRESS 1926 Allen	25. DATE RECD. BY LOCAL REG. NOV 14 1960	26. REGISTRAR'S SIGNATURE <i>Paul Smith, M.D.</i>

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 Not Embalmed, Student Embalmer No. _____
 working under my personal supervision.

Student _____
 Signature of Student Embalmer

Signed Hadley P. Joelle Jr
 Licensed Embalmer No. 9950
 P. O. Address Seaside

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