MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

61-006869

STATE FILE NUMBER

AMENDED

Registration District No. 218 Primary Registration District No. 1003 Registrar's No. 1144

FILED VC FEB 20 1961

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS
Length of stay in 1b
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): ST. ANTHONY HOSPITAL
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): 4121 PENNSYLVANIA
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: INFANT Middle: DANIEL Last: JOSEPH SANDERS
4. DATE OF DEATH: Month: FEB Day: 3 Year: 1961
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: FEB. 3. 1961
9. AGE (last birthday)
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HR: Hours: 10 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country): ST. LOUIS, MO
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: HARRY T SANDERS
13b. MOTHER'S MAIDEN NAME: PATRICIA CURRAN
14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: HARRY T. SANDERS Address: 4121 PENNSYLVANIA

MEDICAL CERTIFICATION

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 Foetalis
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c) 770.0
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. ☐ 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.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
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.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 2-3-61 to 2-3-61 and last saw ~~the~~ him alive on 2-3-61
Death occurred at 6:15 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or Title): Charles A Hester MD
22b. ADDRESS: 5600 S Compton
22c. DATE SIGNED: 2-4-61

23a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
23b. DATE: FEB. 6. 1961
23c. NAME OF CEMETERY OR CREMATORY: SUNSET BURIAL PARK
23d. LOCATION (City, town, or county): ST. LOUIS (State): MO.
24. FUNERAL DIRECTOR: Thomas Kutis ADDRESS: 2906 Gravois
25. DATE RECD. BY LOCAL REG.: FEB 4 1961
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. | SHOULD READ | INSTEAD OF | DATE AMENDED

BY AFFIDAVIT OF DOCUMENT

Call Dr. at 2 P.M.
to see if he has autopsy report.
If so, he will sign them.

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_____ Signed Thomas Cline

Signature of Student Embalmer

Licensed Embalmer No._____

Not Embalmed

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.