SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

child has been followed in our hospital since 5-18-60

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2992 STATE FILE NUMBER -61-011402

AMENDED

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

Child treated at Hosp. since 5-18-1960

BY AFFIDAVIT OF

DOCUMENT

1. PLACE OF DEATH — a. COUNTY FILED APR 7 1961

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

b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) St. Louis — Length of stay in 1b 3hours

c. CITY OR TOWN ~~St Louis~~ — Inside Limits Yes ☑ No ☐

c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) St. Louis Children's — Inside Limits Yes ☑ No ☐

d. STREET ADDRESS (If outside, give location) 4127 Appleberry Lane — Reside on Farm Yes ☐ No ☑

3. NAME OF DECEASED (Type or print) First Debora Middle Denise Last Preston

4. DATE OF DEATH Month 3 Day 28 Year 61

5. SEX Female

6. COLOR OR RACE white

7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐

8. DATE OF BIRTH 11-6-59

9. AGE (last birthday) 1 — IF UNDER 1 YEAR Months 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) Oakharbour Washington

12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME Russell Preston

13b. MOTHER'S MAIDEN NAME May Baity

14. NAME OF HUSBAND OR WIFE none

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

16. SOCIAL SECURITY NO. none

17. INFORMANT Mary Ritter Address 500 S Kingshighway

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

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) 1) Cardiac Arrest

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

DUE TO (b) 2) Intra cranial hemorrhage

DUE TO (c) Lymphocytic Leukemia

INTERVAL BETWEEN ONSET AND DEATH 2 o to

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 204.0

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 3-28-61, to 3-28-61 and last saw her/him alive on 3-28-61

Death occurred at 1:30 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Eugenia M Pierce M.D.

22b. ADDRESS Childrens Hospital

22c. DATE SIGNED MAR 30 1961

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE 3)31)1961

23c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cemetery

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

24. FUNERAL DIRECTOR ADDRESS Collier Mortuary, St. Ann, Mo.

25. DATE RECD. BY LOCAL REG.

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

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 S Sullivan Collier

Licensed Embalmer No. 3382

P. O. Address St. Ann

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.