SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6036 -61-022315 STATE FILE NUMBER

FILED JUL 7 1961

1. PLACE OF DEATH
a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS, MO. — Length of stay in 1b

c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): ST. LOUIS CITY HOSP. #1 — 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,MO — Inside Limits Yes ☐ No ☐

d. STREET ADDRESS (If outside, give location): 2431 DIVISION — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First BABY BOY Middle STANLEY Last BLANKS

4. DATE OF DEATH: Month JUNE Day "25 Year 1961

5. SEX: MALE

6. COLOR OR RACE: NEGRO

7. Married ☐ Widowed ☐ Never Married ☒ Divorced ☐

8. DATE OF BIRTH: 6/25/61

9. AGE (last birthday) — IF UNDER 1 YEAR: Months Days — IF UNDER 24 HR: Hours 3 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): ST. LOUIS, MO

12. CITIZEN OF WHAT COUNTRY: U.S.A

13a. FATHER'S NAME: JAMES

13b. MOTHER'S MAIDEN NAME: INEZ WASHINGTON

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) NO

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: ST.LOUIS CITY HOSP. #1. Address

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

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Immaturity

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

DUE TO (b):

DUE TO (c): 776x

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 JUNE 25, 1961, to June 25, 1961 and last saw her/him alive on JUNE 25, 1961

Death occurred at 10:00 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Wilma Claseman UA

22b. ADDRESS: 1515 Lafayette

22c. DATE SIGNED: 6/25/61

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE: JUN 30 1961

23c. NAME OF CEMETERY OR CREMATORY: Anatomical Board

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

24. FUNERAL DIRECTOR — ADDRESS: Rowland Mortuary Svc. 4104-06 Manchester

25. DATE RECD. BY LOCAL REG.: JUN 29 1961

26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

DATE AMENDED 7/

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

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_____

Signature of Student Embalmer

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.