

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-038003

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318

1003

9541

STATE FILE NUMBER

Registration District No. Primary Registration District No. Registrar's No.

FILED OCT 4 1963

1. PLACE OF DEATH
 a. COUNTY Missouri
 b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis
 Length of stay in 1b
 c. CITY OR TOWN St. Louis Co.
 Inside Limits Yes No
 d. STREET ADDRESS (if outside give location) 9517 Clyde St.
 Inside Limits Yes No
 Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) Baby Sandman
 First Middle Last
 4. DATE OF DEATH Sept. 23 1963
 Month Day Year

5. SEX Female 6. COLOR OR RACE White 7. Married Never Married Widowed Divorced
 8. DATE OF BIRTH 9-23-1963 9. AGE (last birthday) 2 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None 11. BIRTH PLACE (City and state or country) St. Louis Mo 12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME Joseph Sandman 13b. MOTHER'S MAIDEN NAME Delores Gebhardt 14. NAME OF HUSBAND OR WIFE None

15. WAS DECEASED EVER IN THE ARMED FORCES? (Yes, no, or unknown) (If yes, give branch of service) None 16. SOCIAL SECURITY NO. Informant Joseph Sandman 9517 Clyde (25)

18. CAUSE OF DEATH (Enter only one cause per line)
 PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) Immaturity (5 1/2 mo. gestation) Interval between onset and death: 2 1/2 hrs
 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) 776x
 DUE TO (c)

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 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 9-23-63 to 9-23-63 and last saw her/him alive on 9-23-63
 Death occurred at 12:30 pm m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Leo A. Sext M.D.
 22b. ADDRESS 2327 Lafayette St. Louis
 22c. DATE SIGNED 9-24-63

23a. BURIAL, CREMATION, OR REMOVAL (Specify) Removal
 23b. DATE 9-25-1963
 23c. NAME OF CEMETERY OR CREMATORY Resurrection Cem
 23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.

24. FUNERAL DIRECTOR ADDRESS 25. DATE RECD. BY LOCAL REG. 26. REGISTRAR'S SIGNATURE
 J. G. Bernhelle 3819 So Grand St. SEP 24 1963 Road Smith. M.D.

DO NOT WRITE ON THIS STUB
 VS 300 Rev. 4/59
 1
 2 4000
 3
 4 1
 5 0
 6
 7 0
 8 2
 9
 10
 11
 12 65-0
 13
 65
 AMENDED
 DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 SHOULD READ
 ITEM NO.
 BY AFFIDAVIT OF

DOCUMENT
 MEDICAL CERTIFICATION

USE BLACK INK OR TYPEWRITER RIBBON

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 *Geo. W. Winkler* 4611
Not Embalmed

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.