

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

9878 **63-038047**  
STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. \_\_\_\_\_

**FILED OCT 10 1963**

DO NOT WRITE ON THIS STUB

VS 300	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF DOCUMENT
Rev. 4/59	
1	
2 <b>206</b>	
3	
4 <b>3</b>	
5 <b>0</b>	
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7 <b>0</b>	
8 <b>2</b>	
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10	
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12 <b>69-0</b>	
13	

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	
Length of stay in 1b <b>17 Minutes</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Louis State Rock Hospital, Inc.</b>		d. STREET ADDRESS <b>1446 Temple Pl.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Baby girl <del>XXXXXXXXXX</del> Smith</b>		4. DATE OF DEATH Month Day Year <b>October 3, 1963</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Col</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>10-7-63</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>St. Louis Mo U.S.A.</b>
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME <b>Helene Smith</b>	14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	17. INFORMANT <b>Dwight Smith 1446 Temple</b> 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) <b>Premature Birth (5 mo)</b>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last: DUE TO (b) _____ DUE TO (c) _____			<b>776x</b>
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. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 _____ to _____ and last saw her/him alive on _____ Death occurred at <b>6:20 AM</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Royall W. Wir M.D.</b> (Degree or title)		22b. ADDRESS <b>1755 S. Grand Blvd.</b>	
22c. DATE SIGNED <b>10-4-63</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <b>10-4-63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Father, Dukson</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis Mo</b>
24. FUNERAL DIRECTOR <b>J. J. Watson 2769 Chouteau</b> ADDRESS		25. DATE RECD. BY LOCAL REG. <b>OCT 4 1963</b>	26. REGISTRAR'S SIGNATURE <b>Paul Smith M.D.</b>

**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 \_\_\_\_\_

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.