

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-022683

STATE FILE NUMBER 2-3410

FILED JUN 18 1959

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Missouri.	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. John's Hospital	Length of stay in lb.	d. STREET ADDRESS 451 Wilmington Ave.,	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
First	Middle	Last	Month	Day	Year
Deanne			June 5, 1959		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None - Infant		10b. KIND OF BUSINESS OR INDUSTRY Nil		8. DATE OF BIRTH June 5, 1959	
11. BIRTHPLACE (City and state or country) St. Louis, Missouri.		9. AGE (In years last birthday) 0 IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min.			
12. CITIZEN OF WHAT COUNTRY? U.S.A.					

13a. FATHER'S NAME Robert Bellovich		13b. MOTHER'S MAIDEN NAME Mary Hughes		14. NAME OF HUSBAND OR WIFE None	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No Nil		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Robert Vellovich, 451 Wilmington Avenue.,	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary atelectasis DUE TO (b) Prematurity DUE TO (c) 762.5		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)		

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. Month, Day, Year p.m.			

20d. INJURY OCCURRED WHILE AT <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 6-5-59 to 6-5-59 and last saw her alive on 10⁰⁰ a.m. Death occurred at 2⁰⁰ p.m. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Frank S. Robertson, M.D.		22b. ADDRESS 634 N. Grand Ave.		22c. DATE SIGNED 6-6-59	

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 6-6-59		23c. NAME OF CEMETERY OR CREMATORY Miners Cemetery		23d. LOCATION (City, town, or county) (State) Mt. Olive, Illinois.	
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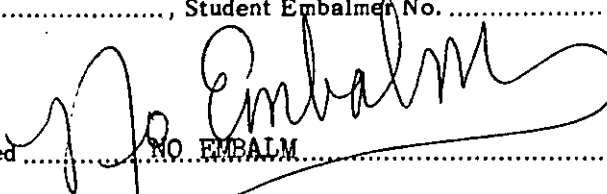
24. FUNERAL DIRECTOR Becker Funeral Home, Mt. Olive, Illinois.		25. DATE RECD. BY LOCAL REG. JUN 6 59		26. REGISTRAR'S SIGNATURE Loan Smith M.D. (H.T.)	
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
ATT diseases in Part I must be causally related

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.