

FILED AUG 5 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25413

State File No.

318

1003

6630

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|---|--|--|----------------------------|--|--|--|--|
| BIRTH NO. <u>46158-49</u> | | REG. DIST. NO. | | PRIMARY REG. DIST. NO. | | Registrar's No. | |
| 1. PLACE OF DEATH a. COUNTY | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY | | | |
| b. CITY (If outside corporate limits, write RURAL and give town) <u>St. Louis, Mo.</u> | | c. LENGTH OF STAY (in this place) | | c. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u> | | TOWN | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>The Peoples Hospital</u> | | | | d. STREET ADDRESS (If rural, give location) <u>11 1159 Cottage Ave.</u> | | | |
| 3. NAME OF DECEASED (Type or Print) <u>Rosalind Williams</u> | | | a. (First) <u>Rosalind</u> | | | b. (Middle) <u>Williams</u> | |
| 4. DATE OF DEATH <u>July 26, 1949</u> | | | c. (Last) | | | 4. DATE (Month) (Day) (Year) | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>Negro</u> | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED? (Specify) <u>Newborn</u> | | 8. DATE OF BIRTH <u>July 21, 1949</u> | |
| 9. AGE (In years last birthday) <u>3</u> | | 10. UNDER 1 YEAR Days <u>5</u> | | 11. UNDER 1 YEAR Hours <u>2</u> | | 12. UNDER 1 YEAR Min. <u>57</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>St. Louis, Missouri</u> | |
| 12. CITIZEN OF WHAT COUNTRY? | | | | 13a. FATHER'S NAME <u>Curlee Williams</u> | | | |
| 13b. MOTHER'S MAIDEN NAME <u>Ruby McDaniels</u> | | | | 14. NAME OF HUSBAND OR WIFE | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT'S SIGNATURE OR NAME <u>Ruby Williams</u> | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>spina bifida Congenital defect - myelocoele</u> | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES | | DUE TO (b) <u>XXXXXXXXXX</u> | | | | | |
| | | DUE TO (c) | | | | | |
| II. OTHER SIGNIFICANT CONDITIONS | | <u>Prematurity</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) <u>15th</u> | | (STATE) <u>Mo</u> | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? <u>TSIX</u> | | | |
| 22. I hereby certify that I attended the deceased from <u>7-21, 1949</u> , to <u>7-26, 1949</u> , that I last saw the deceased alive on <u>7-26, 1949</u> , and that death occurred at <u>3:30</u> p. m., from the causes and on the date stated above. | | | | | | | |
| 23a. SIGNATURE (Degree or title) <u>L. Elizabeth Bowney, M.D.</u> | | | | 23b. ADDRESS <u>46024 Page Blvd.</u> | | 23c. DATE SIGNED <u>7-26-49</u> | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) | | 24b. DATE <u>JUL 31 1949</u> | | 24c. NAME OF CEMETERY OR CREMATORY <u>Anatomical Board</u> | | 24d. LOCATION (City, town, or county) (State) | |
| DATE <u>JUL 31 1949</u> LOCAL REG. | | | | REGISTRAR'S SIGNATURE <u>J. B. Foster</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Rowland Mortuary Service, Inc.</u> | |
| | | | | ADDRESS <u>Manchester Ave</u> | | St. Louis 10, Mo. | |

WRITE PLAINLY—USING UNEADING BLACK INK—MAKE A PERMANENT RECORD

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.

Signed.....

Signed.....
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 this body is not embalmed, fact should be so stated above.