

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED APR 20 1951

1003

State File No. 14904

3202

BIRTH NO. _____ REG. DIST. NO. 318 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 MO. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) ST. Louis MO		c. CITY (If outside corporate limits, write RURAL and give township) TOWN ST. Louis 2119	
c. LENGTH OF STAY (in this place) 2 mos days		d. STREET ADDRESS (If rural, give location) 4200 W. COTE BRILLIANT	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. Louis Children's Hosp			

3. NAME OF DECEASED (Type or Print) a. (First) EDWARD b. (Middle) BUTLER c. (Last) Williams III			4. DATE OF DEATH (Month) (Day) (Year) 4-3-51		
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) SINGLE	8. DATE OF BIRTH 1-26-50	9. AGE (In years last birthday) 1 yr	10. IF UNDER 1 YEAR Months
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) St. Louis MO	
12. CITIZEN OF WHAT COUNTRY? Amer					

13a. FATHER'S NAME EDWARD B WILLIAMS JR		13b. MOTHER'S MAIDEN NAME MEIBAHUE GREEN		14. NAME OF HUSBAND OR WIFE	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME J Egan 500 So Kings Highway	
				ADDRESS	

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, ashenia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Tuberculous meningitis		INTERVAL BETWEEN ONSET AND DEATH 2 mo.
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Pulmonary Tuberculosis (infantile type)		
	DUE TO (c)		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? O.B. 2 X
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22. I hereby certify that I attended the deceased from 1-24-1951, to 4-3-1951, that I last saw the deceased alive on 4-3-1951, and that death occurred at 10:45 Am., from the causes and on the date stated above.

23a. SIGNATURE Don L. Thurston M.D.	(Degree or title)	23b. ADDRESS Children's Hosp	23c. DATE SIGNED 4-3-51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 4/4/51	24c. NAME OF CEMETERY OR CREMATORY St. Peters Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Missouri
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DATE REC'D BY LOCAL REG. APR 5 1951	REGISTRAR'S SIGNATURE J. B. Lassiter	25. FUNERAL DIRECTOR'S SIGNATURE Chas. J. Gates, 4107 Finney Avenue
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WRITE PLAINLY—USING UNFADING 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 _____
working under my personal supervision.

Signed.....
Student Embalmer

Student Embalmer No.....
Signed *John K. Cunningham*
Licensed Embalmer No. 4476

P. O. Address 4107 Finney Avenue

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.