No. 300
10.48

FILED DEC 30 1952

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 43931

BIRTH NO. 88849 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 11097

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

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St Louis Mo
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Park Lane Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri
b. COUNTY St. Louis
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Ferguson. P4349
d. STREET ADDRESS (If rural, give location) 10020 Clarmont

3. NAME OF DECEASED (Type or Print) a. (First) Kenneth b. (Middle) c. (Last) Williams

4. DATE OF DEATH (Month) (Day) (Year) 11-30-52

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Sep Premature

8. DATE OF BIRTH 11-30-52

9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. 2 HS

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None

10b. KIND OF BUSINESS OR INDUSTRY None

11. BIRTHPLACE (City and State or Foreign Country) St Louis Mo

12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Willard Williams

13b. MOTHER'S MAIDEN NAME Vistana Hackstadt

14. NAME OF HUSBAND OR WIFE None

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT'S SIGNATURE OR NAME Vistana Hackstadt ADDRESS 10020 Clarmont Ferguson Mo

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) Prematurity @ 6 mo.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

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)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR? 776X

22. *I hereby certify that I attended the deceased from* 11-30, 1952, *to* 11-30, 1952, *that I last saw the deceased alive on* 11-30, 1952, *and that death occurred at* 9 45 p *m., from the causes and on the date stated above.*

23a. SIGNATURE Clyde E. Kane (Degree or title) M.D.

23b. ADDRESS 706 Walton

23c. DATE SIGNED 12-2-52

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal

24b. DATE 12-2-52

24c. NAME OF CEMETERY OR CREMATORY Memorial Park

24d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.

DATE REC'D BY LOCAL REG. DEC 2 1952

REGISTRAR'S SIGNATURE J Carl Smith MD MB

25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe, 4700 Washington Blvd. ADDRESS

(Licensed Embalmer's Statement on Reverse Side)

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 .....
Student Embalmer

Signed No Embalm

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.