

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

**34458**

State File No. ....

FILED OCT 2 - 1953  
 BIRTH NO. 66783 REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 541 Registrar's No. 2367

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission).			
a. COUNTY <u>St Louis</u>		a. STATE <u>Missouri</u>		b. COUNTY <u>St Louis</u>	
b. CITY (If outside corporate limits, write RURAL and give town) <u>Clayton, Mo</u>		c. LENGTH OF STAY (at this place) <u>3 hours</u>		c. CITY OR TOWN <u>Kuloch #091</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St Louis Co Hosp</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b>			<b>4. DATE OF DEATH</b>		
a. (First) <u>Baby Girl</u>			b. (Middle) <u>Williams</u>		
c. (Last) <u>Williams</u>			(Month) (Day) (Year) <u>8 25 53</u>		
<b>5. SEX</b> <u>F3</u>		<b>6. COLOR OR RACE</b> <u>Col</u>		<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</b> (Specify) <u>Not married</u>	
<b>8. DATE OF BIRTH</b> <u>8-25-53</u>		<b>9. AGE</b> (In years last birthday) <u>3</u>		IF UNDER 1 YEAR: Months <u>0</u> Days <u>40</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>None</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>None</u>		<b>11. BIRTHPLACE</b> (City and State or Foreign Country) <u>Clayton Missouri</u>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S</u>		<b>13a. FATHER'S NAME</b> <u>Unknown</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>Delores Williams</u>	
<b>14. NAME OF HUSBAND OR WIFE</b> <u>None</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>None</u>	
<b>17. INFORMANT'S SIGNATURE OR NAME</b> <u>Delores Williams</u>		<b>18. ADDRESS</b> <u>341 McHenry</u>			
<b>18. CAUSE OF DEATH</b> Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		<b>MEDICAL CERTIFICATION</b>			
		<b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*</b> (a) <u>Immaturity</u>			
		<b>ANTECEDENT CAUSES</b>			
		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____			
		DUE TO (c) _____			
		<b>II. OTHER SIGNIFICANT CONDITIONS</b>			
		Conditions contributing to the death but not related to the disease or condition causing death. _____			
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b>	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT SUICIDE HOMICIDE</b> (Specify)		<b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)</b>	
				<u>772x</u>	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>	
<b>22. I hereby certify that I attended the deceased from <u>8-25</u>, 19<u>53</u>, to <u>8-25</u>, 19<u>53</u>, that I last saw the deceased alive on <u>8-25</u>, 19<u>53</u>, and that death occurred at <u>11:30 pm.</u>, from the causes and on the date stated above.</b>					
<b>23a. SIGNATURE</b> <u>George R. Kruitmeyer, MD</u>		<b>23b. ADDRESS</b> <u>601 So Brentwood Blvd</u>		<b>23c. DATE SIGNED</b> <u>8-27-53</u>	
<b>24a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Cremation</u>		<b>24b. DATE</b> <u>9/3/53</u>		<b>24c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Louis City Crematory</u>	
				<b>24d. LOCATION</b> (City, town, or county) (State) <u>6800 Arsenal, St Louis, Mo</u>	
<b>DATE REC'D BY LOCAL REG.</b> <u>9/3/53</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Herbert R. Spink, MD</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>St. Louis Co. Hospital - Col. Reed</u>	
				<b>ADDRESS</b>	

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

(Signed Embalmer's Statement on Reverse Side)

Not embalmed



Curtis H. Loh, M.D.  
Supt. & Medical Director.

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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.