

FILED MAY 26 1955

STANDARD CERTIFICATE OF DEATH

State File No. 17125

BIRTH NO. 41239-55 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 4337

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) OR TOWN St. Louis		c. LENGTH OF STAY (in this place)	c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION De Paul Hosp.			e. STREET ADDRESS (If rural, give location) 5 5969 Maple Ave. 20570		
3. NAME OF DECEASED (Type or Print) a. (First) Susan b. (Middle) Marie c. (Last) Williams		4. DATE OF DEATH (Month) (Day) (Year) 5-15-55			
5. SEX Female	6. COLOR OR RACE w	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH 5-14-55	9. AGE (In years last birthday) 2	IF UNDER 1 YEAR: Days 7
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.
13a. FATHER'S NAME Rex Delmar Williams		13b. MOTHER'S MAIDEN NAME Nancy Lee Moss		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Nancy Williams		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prematurity			INTERVAL BETWEEN ONSET AND DEATH 31 hrs
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		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.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) (STATE)		
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 776x		
22. I hereby certify that I attended the deceased from May 14, 1955 to May 15, 1955, that I last saw the deceased alive on May 15, 1955 and that death occurred at 11:10 p.m., from the causes and on the date stated above.					
23a. SIGNATURE John G. M. Jurney MD		(Degree or title)		23b. ADDRESS 5014 Thekla House	23c. DATE SIGNED 5/17/55
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 5/17/55	24c. NAME OF CEMETERY OR CREMATORY Calvary	24d. LOCATION (City, town, or county) (State) St. Louis Mo.		
DATE REC'D BY LOCAL REG. MAY 17 1955	REGISTRAR'S SIGNATURE J. Carl Smith		25. FUNERAL DIRECTOR'S SIGNATURE Max White		ADDRESS Ferguson, Mo.

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADEING 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.

Student.....
Signature of Student Embalmer

Nath Embalmed

Signed.....
Eleana Poince

Licensed Embalmer No. *340*

P. O. Address *Jennings*

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.