M81122

FILED SEP 4 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30170

STATE FILE NUMBER 7624

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO. Inside Limits Yes ☐ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. #1. Length of stay in 1b 25 / 2

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY
c. CITY OR TOWN ST. LOUIS, MO. Inside Limits Yes ☐ No ☐
d. STREET ADDRESS 1905 CARR APT. 904 (If outside, give location) Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First BABY Middle GIRL Last WILLIAMS

4. DATE OF DEATH Month JUNE Day 13 Year 1957

5. SEX FEMALE 3

6. COLOR OR RACE NEGRO

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ X

8. DATE OF BIRTH 6/13/57

9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. 55

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 country) ST. LOUIS, MO. 0

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME ~~XXXXXXXX~~ CLYDE Williams

14. MOTHER'S MAIDEN NAME SALLY BELLE Rice

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

16. SOCIAL SECURITY NO. NONE

17. INFORMANT Address ST. LOUIS CITY HOSP. #1.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Prematurity
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c) 776X

PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 6/13/57, to 6/13/57 and last saw her him alive on 6/13/57
Death occurred at 10:30 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE L. B. Klein (Degree or title) M.D.

22b. ADDRESS 1515 LAFAYETTE AVE.

22c. DATE SIGNED 6/14/57.

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE 8-31-57

23c. NAME OF CEMETERY OR CREMATORY Anatomical Board

23d. LOCATION (City, town, or county) St. Louis, Mo. (State)

24. FUNERAL DIRECTOR Rowland-Aker ADDRESS 4104 Manchester

25. DATE RECD. BY LOCAL REG. AUG 15 57

26. REGISTRAR'S SIGNATURE J. Earl Smith MD

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Diseases in Part I must be casually related. Coroner cannot certify to a death due to murder, suicide.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was e

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.
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..