

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-046521

STATE FILE NUMBER  
12608

FILED JAN 12 1958

Registration District No. 318 Primary Registration District No. 1003

Registrar's No.

300  
1-57

0

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Saint Louis Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Park Lane Hospital		Length of stay in lb 3 days	d. STREET ADDRESS (If outside, give location) 4253 Farlin Avenue
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last VELMA ORA WILLIAMS			4. DATE OF DEATH Month Day Year December 28, 1958		
--	--	--	---	--	--

5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 9, 1903	9. AGE (In years from birthday) 55	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
------------------	---------------------------	---	---------------------------------	---------------------------------------	--------------------------------	--------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector	10b. KIND OF BUSINESS OR INDUSTRY Rexall Drug Co.	11. BIRTHPLACE (City and state or country) Petterson Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
--	--	--	--

13a. FATHER'S NAME Thomas Malloy	13b. MOTHER'S MAIDEN NAME Ida Jones	14. NAME OF HUSBAND OR WIFE Donald L. Williams
-------------------------------------	--	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no none	16. SOCIAL SECURITY NO. 499-07-0402	17. INFORMANT Address Donald L. Williams 4253 Farlin Avenue.
--	--	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis Hypertension		INTERVAL BETWEEN ONSET AND DEATH 12 11
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Hypertension	443x
	DUE TO (c)	
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 <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
---	--

20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	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 Death occurred at Dec 27 1958, to Dec 28 1958 and last saw her alive on Dec 27 1958 12:20 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.
---

22a. SIGNATURE Clyde E. Kane (Degree or title) M.D.	22b. ADDRESS 706 Walton	22c. DATE SIGNED 12-29-58
---	-------------------------	---------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE December 30, 1958	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri
--	--------------------------------	--	---

24. FUNERAL DIRECTOR Shepard Funeral Home,	ADDRESS 1167 Hamilton Ave	25. DATE RECD. BY LOCAL REG. DEC 29 58	26. REGISTRAR'S SIGNATURE Carl Smith
---	------------------------------	---	---

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

**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 *Stanley H. Aifow* .....  
Licensed Embalmer No. *4493* .....  
P. O. Address *St. L.* .....

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.