

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-007801

STATE FILE NUMBER 1454

CB 26 1959

Registration District No.

Primary Registration District No.

Registrar's No.

300
-57

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
b. CITY (If outside corporate limits; give TOWNSHIP only) OR TOWN ST. LOUIS, MO.		c. CITY OR TOWN ST. LOUIS, MO.	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION CITY HOSPITAL		d. STREET ADDRESS (If outside, give location) 2220 COLE	

3. NAME OF DECEASED (Type or print) First Kevin Middle Last Williams BABY BOY WILLIAMS			4. DATE OF DEATH Month 1 Day 27 Year 59		
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/26/59	9. AGE (In years last birthday)	IF UNDER 1 YEAR IF UNDER 24 HRS. Months 1 Days 1 Hours 1 Min.
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.		12. CITIZEN OF WHAT COUNTRY? U.S.A

13a. FATHER'S NAME John F. Williams UNKNOWN		13b. MOTHER'S MAIDEN NAME Arden Muskin PANNIE WILLIAMS		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. no		17. INFORMANT ST. LOUIS CITY HOSP, #1.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Neonatal Atelectasis			INTERVAL BETWEEN ONSET AND DEATH 24 hrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Prematurity			
DUE TO (c) 762.5			
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 checked="" type="checkbox"/> NO <input 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.) ITEM 3, 13a, 13b CORRECTED	
20c. TIME OF INJURY Hour 12:00 Month 1 Day 27 Year 59 a.m. p.m.		BY AFFIDAVIT OF Enforcement 3-16-59	

20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 ST. LOUIS, MO.	COUNTY	STATE
21. I attended the deceased from 1-26-59 to 1-27-59 and last saw him alive on 1-27-59 Death occurred at 12:00 P m on the date stated above; and to the best of my knowledge, from the causes stated.					

22a. SIGNATURE Michael S. Rossignol, M.D.		(Degree or title)	22b. ADDRESS 1515 LAFAYETTE	22c. DATE SIGNED 1-27-59
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23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 2-28-59	23c. NAME OF CEMETERY OR CREMATORY Anatomical Board	23d. LOCATION (City, town, or county) (State) St. Louis, Mo.
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24. FUNERAL DIRECTOR Rowland Aber 4104 Manchester	ADDRESS	25. DATE RECD. BY LOCAL REG. FEB 11 59	26. REGISTRAR'S SIGNATURE Loan Smith, M.D.
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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

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.