

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-019782

STATE FILE NUMBER

2 4689

FILED MAY 26 1959 Registration District No. Primary Registration District No. Registrar No.

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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 ST. LOUIS CITY HOSP #1.		d. STREET ADDRESS 1405 S. EWING	

3. NAME OF DECEASED (Type or print) First ODELL Middle Last WILLIAMS			4. DATE OF DEATH Month APRIL Day 24 Year 1959		
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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 4/24/59	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NO	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
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13a. FATHER'S NAME WALTER WILLIAMS	13b. MOTHER'S MAIDEN NAME AGNES SIMPSON	14. NAME OF HUSBAND OR WIFE
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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.	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital atelectasis		INTERVAL BETWEEN ONSET AND DEATH
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.)
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	

20d. INJURY OCCURRED WHILE AT WORK <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
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21. I attended the deceased from **4/24/59** to **4/24/59** and last saw her alive on **4/24/59**
Death occurred at **9:15 A.M.** on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Michael S. Passagay, M.D.	22b. ADDRESS 1515 LAFAYETTE AVE	22c. DATE SIGNED 5/7/59
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23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 5-30-59	23c. NAME OF CEMETERY OR CREMATORY Anatomical Board	23d. LOCATION (City, town, or county) St. Louis, Mo.	(State)
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24. FUNERAL DIRECTOR Rowland Abel 404 Manchester	ADDRESS	25. DATE RECD. BY LOCAL REG. MAY 14 '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.