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|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)   |  |  |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>St. Louis</b>   |  |   |  | Length of stay in 1b<br><b>2 weeks</b>  |  | c. CITY OR TOWN <b>Ironton</b>   |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>St. Louis Children's</b>  |  |   |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |  | d. STREET ADDRESS (If outside, give location)  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Linda</b> Middle <b>Gail</b> Last <b>Williams</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>Dec.</b> Day <b>30</b> , Year <b>1960</b>  |  |  |  |
| 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>3-27-60</b>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>None</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>  |  | 9. AGE (last birthday)<br><b>9</b>  |  | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S. A.</b>  |  |
| 11. BIRTHPLACE (City and state or country)<br><b>Ironton, Missouri</b>  |  |   |  | 13. CITIZEN OF WHAT COUNTRY<br><b>U.S. A.</b>   |  |  |  |
| 13a. FATHER'S NAME<br><b>Enoch Daniel Williams</b>  |  |   |  | 13b. MOTHER'S MAIDEN NAME<br><b>Velma Lietz</b>   |  | 14. NAME OF HUSBAND OR WIFE<br><b>never married</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>NO</b>   |  |   |  | 16. SOCIAL SECURITY NO.<br><b>None</b>  |  | 17. INFORMANT<br><b>Jane Henrichsen</b> Address <b>500 S. Kingshighway</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac + Respiratory Arrest</b><br>DUE TO (b) <b>Purulent Bacterial meningitis</b><br>DUE TO (c) <b>Convulsive Disorder</b><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. |  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>12/16/60</b><br><b>12/30/60</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e)<br><b>3403</b>  |  |   |  |   |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |  |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour<br>a.m.<br>p.m.   |  | Month, Day, Year  |  |   |  |  |  |
| 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   |  |
| 21. I attended the deceased from <b>6:50pm</b>  |  | to <b>12-16-60</b>  |  | and last saw her/him alive on <b>12-30-60</b>   |  | Death occurred at <b>6:50pm</b> on the date stated above, and to the best of my knowledge, from the causes stated.   |  |
| 22a. SIGNATURE (Degree or title)<br><b>J. Neil Middendorf M.D.</b>  |  |   |  | 22b. ADDRESS<br><b>500 S. Kingshighway</b>  |  | 22c. DATE SIGNED<br><b>12-30-60</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>   |  | 23b. DATE<br><b>12-31-60</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Local</b>  |  | 23d. LOCATION (City, town, or county) (State)<br><b>Ironton, Mo.</b>   |  |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Albert H. Hoppe Inc., 4700 Washington, Blvd.</b>   |  |   |  | 25. DATE RECD. BY LOCAL REG.<br><b>DEC 31 1960</b>  |  | 26. REGISTRAR'S SIGNATURE<br><b>J. Neil Middendorf</b>   |  |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Robert M. Murray*

Licensed Embalmer No. 3749

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.