ISSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 1569 -61-007030 STATE FILE NUMBER

FILED VS FEB 28 1961

1. PLACE OF DEATH
a. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE b. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis, Mo. — Length of stay in Tb

c. CITY OR TOWN: ST.LOUIS,MO — Inside Limits Yes ☐ No ☐

c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): St. Louis City Hosp. # 1 — Inside Limits Yes ☐ No ☐

d. STREET ADDRESS (If outside, give location): 1917 FRANKLIN — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First Baby Boy — Middle — Last Williams

4. DATE OF DEATH: Month 2 Day 4 Year 61

5. SEX: MALE

6. COLOR OR RACE: NEGRO

7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 2/4/61

9. AGE (last birthday) — IF UNDER 1 YEAR: Months Days — IF UNDER 24 HR: Hours Min. 34

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): XXXXXXXXXXXXXXXX

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: JULIUS WILLIAMS

13b. MOTHER'S MAIDEN NAME: BERNICE HILL

14. NAME OF HUSBAND OR WIFE

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: ST.LOUIS CITY HOSP. #1. Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Immaturity

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last: DUE TO (b)

DUE TO (c) 776+

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

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 2/4/61, to 2/4/61 and last saw her/him alive on 2/4/61

Death occurred at 8:00 p.m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Gerald J Dunlop M.D.

22b. ADDRESS: 1515 Lafayette Ave.

22c. DATE SIGNED: 2/5/61

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE: FEB 28 1961

23c. NAME OF CEMETERY OR CREMATORY: Anatomical Board

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

24. FUNERAL DIRECTOR: Rowland Mortuary Svc. ADDRESS: 4104-06 Manchester

25. DATE RECD. BY LOCAL REG.: FEB 16 1961

26. REGISTRAR'S SIGNATURE: Carl Smith, M.D.

DATE AMENDED | INSTEAD OF | SHOULD READ | ITEM NO. | DOCUMENT | BY AFFIDAVIT OF

MEDICAL CERTIFICATION

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_____ Signed_____

Signature of Student Embalmer

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.