SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9291 STATE FILE NUMBER -61-039396

FILED OCT 26 1961

1. PLACE OF DEATH
a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis, Missouri — Length of stay in 1b: 5 days

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Cardinal Glennon Memorial — Inside Limits: Yes ☒ No ☐

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

c. CITY OR TOWN: Overland, Missouri — Inside Limits: Yes ☐ No ☐

d. STREET ADDRESS (If outside, give location): 44 Kalin Drive — Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Maureen Middle: Ann Last: Williams

4. DATE OF DEATH: Month 10 Day 7 Year 61

5. SEX: Female

6. COLOR OR RACE: White

7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 10/2/61

9. AGE (last birthday): IF UNDER 1 YEAR Months Days 5 IF UNDER 24 HR Hours 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, Missouri

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: Donald E. Williams

13b. MOTHER'S MAIDEN NAME: Maureen A. Taylor

14. NAME OF HUSBAND OR WIFE: None

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.: None

17. INFORMANT: Donald Williams Address: 44 Kalin Dr., Overland, Mo.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Staphylococcal Pneumonitis — INTERVAL BETWEEN ONSET AND DEATH: 2 Days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 763.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Meconium Ileus – Status Post Operative 3 Days

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 10-4-61, to 10-7-61 and last saw her alive on 10-7-61
Death occurred at 2:00 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): John W. McMahon, M.D.

22b. ADDRESS: 1575 So. Grand

22c. DATE SIGNED: 10-8-61

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 10-9-61

23c. NAME OF CEMETERY OR CREMATORY: Calvary

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

24. FUNERAL DIRECTOR: Ortmann Funeral Home ADDRESS: 9222 Lackland Overland

25. DATE RECD. BY LOCAL REG.: OCT 8 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 NOT embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____ Signed A. C. Ostmann

Signature of Student Embalmer

Note: Licensed Embalmer No. 3478

DECEASED WAS NOT Embalmed. 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.