

FILED OCT 12 1945 **STANDARD CERTIFICATE OF DEATH**

State File No. _____

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **8621**

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **St. Louis Children's Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **000**
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **5925 Dale Ave.**
(If rural, give location) **4**
(e) Citizen of foreign country? **0** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Donna Sue Williams**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **No**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Infant**
6. (b) Name of husband or wife **Infant** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Aug. 23 1944**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
1 1 11 hr. min.

9. Birthplace **Corning Arkansas**
(City, town, or county) (State or foreign country)

10. Usual occupation **Infant**

11. Industry or business _____

MOTHER FATHER { 12. Name **Lester L. Williams**
13. Birthplace **Mobile Alabama**
(City, town, or county) (State or foreign country)
14. Maiden name **Wanda Meeks**
15. Birthplace **Corning Arkansas**
(City, town, or county) (State or foreign country)

16. (a) Informant **Lester L. Williams**

(b) Address **5925 Dale Ave.**

17. (a) **Removal** (b) Date thereof **10-5-45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Corning, Arkansas**

18. (a) Signature of funeral director **Albert H. Hoppe**

(b) Address **4700 Washington Blvd.**

19. (a) **OCT 5 1945** (b) **J. F. Bredeck**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **4th**
year **1945** hour **12** minute **40 P. M.**

21. I hereby certify that I attended the deceased from **10-3-45**, 19____, to **10-4**, 19**45**;
that I last saw **her** alive on **10-4**, 19**45**;
and that death occurred on the date and hour stated above.

Immediate cause of death **Meningococemia**

Due to _____

Due to _____

Other conditions **6**
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature **R. G. Blatten** (M. D. or other) _____
Address **Dr. King's** Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

8621

8621

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed..... *W. Wilkinson*.....

Licensed Embalmer No..... *3578*.....

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 this body is not embalmed, fact should be so stated above.