

FILED AUG 13 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

25406

State File No. \_\_\_\_\_

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>6869</b>			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MISSOURI</b>				b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST. LOUIS</b>		c. LENGTH OF STAY (in this place) <b>1 HR. 56 MIN.</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST. LOUIS</b>		d. STREET ADDRESS (If rural, give location) <b>4020 A LACLEDE</b>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>LUTHERAN HOSPITAL</b>				d. STREET ADDRESS (If rural, give location) <b>18 4020 A LACLEDE</b>					
3. NAME OF DECEASED (Type or Print) a. (First) <b>BABY</b>		b. (Middle) <b>BOY</b>		c. (Last) <b>WILLIAMS</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>AUGUST 7, 1949</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) _____		8. DATE OF BIRTH <b>AUGUST 7, 1949</b>			
9. AGE (In years last birthday) _____		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 1 HR. Hours _____ Min. _____		11. BIRTHPLACE (State or foreign country) <b>MISSOURI</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____				10b. KIND OF BUSINESS OR INDUSTRY _____		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>			
13a. FATHER'S NAME <b>FRANCIS LEE WILLIAMS</b>			13b. MOTHER'S MAIDEN NAME <b>DORA MAY VANDERLIND</b>			14. NAME OF HUSBAND OR WIFE _____			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <b>FRANCIS LEE WILLIAMS</b>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Central Respiratory Failure</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b>			
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) <b>Premature Delivery</b>					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		DUE TO (c) <b>at 5 months</b>					
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) <b>159</b>					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____ <b>776X</b>					
22. I hereby certify that I attended the deceased from <sup>6:28</sup> am. 8-7, 1949, to <sup>8:24</sup> am. 8-7 1949, that I last saw the deceased alive on <b>8-7, 1949</b> and that death occurred at <sup>9:24</sup> am., from the causes and on the date stated above.									
23a. SIGNATURE <b>Walter H. Doepf</b>				23b. ADDRESS <b>3108 S. Grand</b>		23c. DATE SIGNED <b>8-7-49</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24b. DATE <b>AUG. 8, 1949</b>		24c. NAME OF CEMETERY OR CREMATORY <b>SACRED HEART FLORISSANT, Mo.</b>		24d. LOCATION (City, town, or county) (State) <b>Florissant, Mo.</b>			
DATE REC'D BY LOCAL REGISTRAR <b>AUG 8 1949</b>		REGISTRAR'S SIGNATURE <b>J. Blaser</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>James Appleby</b> ADDRESS: <b>580 WASHINGTON ST. FLORISSANT MO</b>					

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

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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.....

*Not Embalmed*

Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

Signed.....

Licensed Embalmer No. *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 this body is not embalmed, fact should be so stated above.