

FILED JAN 14 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 43078

BIRTH NO. 84983-49 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1000 Registrar's No. 11274

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis Mo		c. CITY (If outside corporate limits, write RURAL and give township) University City Mo	
c. LENGTH OF STAY (In this place) 1 day		d. STREET ADDRESS (If rural, give location) N. W. 6527 Carbett	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis Children's			
3. NAME OF DECEASED (Type or Print) a. (First) Doris b. (Middle) Elaine c. (Last) Williams		4. DATE OF DEATH (Month) (Day) (Year) 12 - 8 - 49	
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER-MARRIED, WIDOWED, DIVORCED (Specify) /	8. DATE OF BIRTH 12-5-49
9. AGE (In years last birthday)		10. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St. Louis County Mo
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		12. CITIZEN OF WHAT COUNTRY? American	
13a. FATHER'S NAME Leah H. Williams		14. NAME OF HUSBAND OR WIFE	
13b. MOTHER'S MAIDEN NAME Anna Thaler		17. INFORMANT'S SIGNATURE OR NAME J. Egan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Esophageal stricture. Tracheo-esophageal fistula ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION 12-8-49		19b. MAJOR FINDINGS OF OPERATION as listed in 18-1(a)	
19c. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) 1599		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? 7512	
22. I hereby certify that I attended the deceased from 12-7, 1949, to 12-8, 1949, that I last saw the deceased alive on 12-8, 1949, and that death occurred at 10:10 p. m., from the causes and on the date stated above.			
23a. SIGNATURE W. E. Klingberg MD		23b. ADDRESS 500 So. Kingshighway	
23c. DATE SIGNED			
24a. BURIAL, CREMATION, REMOVAL (Specify) DEC 31 1949		24b. NAME OF CEMETERY OR CREMATORY Anatomical Board	
24c. LOCATION (City, town, or county) (State)			
DATE REC'D BY LOCAL REG. DEC 31 1949		REGISTRAR'S SIGNATURE J. B. Basater	
25. FUNERAL DIRECTOR'S SIGNATURE Rowland Service		ADDRESS 4484	

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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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed.....

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