THE DIVISION OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

538

STATE FILE NUMBER

FILED FEB 4 1957

506-57 Registration District No. 53 Primary Registration District No. 3010 Registrar's No. 115

1. PLACE OF DEATH
a. COUNTY Cape Girardeau
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Cape Girardeau — Inside Limits Yes ☑ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Southeast Mo Hosp. — Length of stay in 1b 4 hrs 30 min.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo — b. COUNTY Newmadrid
c. CITY OR TOWN Matthews — Inside Limits Yes ☐ No ☑
d. STREET ADDRESS (If outside, give location) R-1 Box 82 — Reside on Farm Yes ☐ No ☐

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

4. DATE OF DEATH Month Day Year: Jan 29-1957

5. SEX: Male
6. COLOR OR RACE: Cal
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ Inf
8. DATE OF BIRTH: 1-29-1957
9. AGE (In years last birthday): —
IF UNDER 1 YEAR: Months — Days —
IF UNDER 24 HRS.: Hours 4 Min. 30

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Inf
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (City and state or country): Cape Girardeau Mo
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: LeRoy Williams
14. MOTHER'S MAIDEN NAME: Velma Luckett

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT Address: LeRoy Williams, Matthews Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Placenta Previa — INTERVAL BETWEEN ONSET AND DEATH: 2 da.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) ____ DUE TO (c) ____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Prematurity — 6½-7 mo. 7615
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 2

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 1-29-57, to 1-29-57 and last saw her/him alive on 1-29-57
Death occurred at 2:55 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): William F. Oehler MD
22b. ADDRESS: Cape Girardeau Mo.
22c. DATE SIGNED: 1-31-57

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 1-30-57
23c. NAME OF CEMETERY OR CREMATORY: Sand Hill Cem
23d. LOCATION (City, town, or county) (State): Newmadrid Mo

24. FUNERAL DIRECTOR ADDRESS: Taken care of by Family.
25. DATE RECD. BY LOCAL REG.: 1-31-1957
26. REGISTRAR'S SIGNATURE: C. C. Summers

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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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 em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Not Embalmed

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (
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.