

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

46481

STATE FILE NUMBER

FILED DEC 20 1957

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 11263

S. 300
v. 1-57
All diseases in Part I must be causally related.
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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, give TOWNSHIP only) OR TOWN St. Louis,		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis,		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 15 Lutheran Hosp.			Length of stay in 1b		d. STREET ADDRESS 2447 5244 Miami Str.		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CARL Middle F. Last WILLIAMS				4. DATE OF DEATH Month Nov. Day 23, Year 1957				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 14, 1904		9. AGE (In years last birthday) 55	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Buyer			10b. KIND OF BUSINESS OR INDUSTRY Famous-Barr Co.		11. BIRTHPLACE (City and state or country) Fountain Run, Ky.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Samuel Y. Williams			13b. MOTHER'S MAIDEN NAME Effie Jones			14. NAME OF HUSBAND OR WIFE Ruth Williams		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 1-89-01-9651		17. INFORMANT Address Ruth Williams-5244 Miami St.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Generalized Peritonitis & Intestinal Obstruction							INTERVAL BETWEEN ONSET AND DEATH 7 days	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Generalized Acute Zelenative Colitis							10 days	
DUE TO (c) 572.2								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18):					
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.								
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 1945 to Nov. 23, 1957 and last saw her alive on Nov. 22, 1957 Death occurred at 1:30 A. m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE M.D. (Degree or title) Leo H. Hauer - M.D. Herman M.D.			22b. ADDRESS 3701 Grand Square			22c. DATE SIGNED 11/23/57		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE Nov. 25, 1957	23c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park		23d. LOCATION (City, town, or county) St. Louis County, Mo.		(State)	
24. FUNERAL DIRECTOR Kriegshauser-4228 S. Kingshighway				25. DATE RECD. BY LOCAL REG. NOV 25 57		26. REGISTRAR'S SIGNATURE J. Carl Smith, M.D. M.J.B.		

(Licensed Embalmer's Statement on Reverse Side)

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
Signature of Student Embalmer

Signed *William C. White*

Licensed Embalmer No. *7291*

P. O. Address *4228 Ashland Highway*

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.