

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-023887
STATE FILE NUMBER

FILED JUN 27 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

6175

S. 300
v. 1-57
0

1. PLACE OF DEATH a. COUNTY -		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR St. Louis TOWN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 05 Bethesda General Hospital		Length of stay in 1b 2,755 days	d. STREET ADDRESS (If outside, give location) 3655 Vista 2/8/58 Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Lee Williams			4. DATE OF DEATH Month Day Year June 15 1958
5. SEX male <input checked="" type="checkbox"/>	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 3, 1919
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	9. AGE (In years last birthday) 39 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (City and state or country) Point Pleasant, Missouri		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13a. FATHER'S NAME Joe Williams		13b. MOTHER'S MAIDEN NAME Ida Keller	
14. NAME OF HUSBAND OR WIFE not married.		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Sister: Mrs. Flowers 2604 S. Grand Ave. St. Louis	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Pylonephritis, Chronic</u> DUE TO (c) <u>Paraplegia, due to old poliomyelitis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>under 1 yr</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 WORK <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 <u>Nov 28, 1950</u> to <u>June 15, 1958</u> and last saw him alive on <u>June 15, 1958</u> Death occurred at <u>9:35 P.M., June 15, 1958</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22. SIGNATURE (Degree or title) <u>Thomas Parker M.D.</u>		22b. ADDRESS <u>4660 Delaplacade, St. Louis, Mo.</u>	
22c. DATE SIGNED <u>6/19/58</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
23b. DATE <u>6-18-58</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Calvary</u>	
23d. LOCATION (City, town, or county) (State) <u>St. Louis, Missouri</u>		24. FUNERAL DIRECTOR ADDRESS <u>McLaughlin Funeral Home, Inc. 2301 Lafayette, St. Louis, Mo.</u>	
25. DATE RECD. BY LOCAL REG. <u>JUN 17 '58</u>		26. REGISTRAR'S SIGNATURE <u>Carl Smith</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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

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 *James R. Chapman*

Licensed Embalmer No. *4550*

P. O. Address *H. Fair*

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.