

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-027862

STATE FILE NUMBER

Health,
Welfare
Public
Service

300
1-56

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. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

| | | | | |
|---|----------------------------------|--|--|---|
| FILED JUL 24 1958 | | Registration District No. 317 | Primary Registration District No. 500 | Registrar's No. 1819 |
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | | |
| a. COUNTY <u>St. Louis County</u> | | a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u> | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Koch</u> | | c. CITY OR TOWN <u>St. Louis</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Koch Hospital</u> | | Length of stay in lb <u>33 days</u> | d. STREET (If outside, give location) ADDRESS <u>2234 Lasalle</u> | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) | | 4. DATE OF DEATH | | Month Day Year |
| First Middle Last <u>ANDREW LEWIS WILLIAMS</u> | | <u>July 8 1958</u> | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Negro</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>7/13/14</u> | 9. AGE (In years last birthday) <u>43</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>City Street Dept.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>St. Louis City</u> | 11. BIRTHPLACE (City and state or country) <u>Tennessee</u> | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
| 13. FATHER'S NAME <u>Horace Williams</u> | | 14. MOTHER'S MAIDEN NAME <u>Maggie Bonds</u> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u> | | 16. SOCIAL SECURITY NO. <u>413-20-7596</u> | 17. INFORMANT <u>Calbie Luc Williams 2334 Lasalle St</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | INTERVAL BETWEEN ONSET AND DEATH. <u>about 50 min.</u> |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest during surgery -</u> | | | | ? |
| 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) <u>Marked Bronchiectasis right middle and lower lobes</u> | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u> |
| 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 | | |
| 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>July 1, 1958</u> to <u>July 8, 1958</u> and last saw ^{her} alive on <u>July 8, 1958</u> | | | | |
| Death occurred at <u>10:40</u> <u>A</u> m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | |
| 22a. SIGNATURE <u>Benson R. Helton</u> | | (Degree or title) <u>M.D.</u> | 22b. ADDRESS <u>Barnes Hospital St. Louis Mo.</u> | 22c. DATE SIGNED <u>7/8</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 23b. DATE <u>7-9-1958</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Shiloh</u> | 23d. LOCATION (City, town, or county) <u>Ms. Kenzie</u> | (State) <u>TENN</u> |
| 24. FUNERAL DIRECTOR <u>J. H. Randle & Son 3133 Bell Ave</u> | | ADDRESS | 25. DATE RECD. BY LOCAL REG. <u>7-9-58</u> | 26. REGISTRAR'S SIGNATURE <u>Herbert P. Donke M.D.</u> |

JUL 2 1958

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 *Arthur L. Belliard*

Licensed Embalmer No. *42*

P. O. Address *310*

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.