

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-007799

STATE FILE NUMBER

2 1514

FILED MAR 2 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

Registrar's No. \_\_\_\_\_

300

-57

Office 1294

|   |  |   |   |
|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY                                 |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>St. Louis</u>   |  | c. CITY OR TOWN <u>St. Louis</u>  |   |
| Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>  |  | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |   |
| 3. FULL NAME OF (IF NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>St. Louis Children's D.O.A.</u>   |  | d. STREET ADDRESS (If outside, give location)<br><u>4733 A-Washington Ave.</u>  |   |
| Length of stay in 1b  |  | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  |   |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><u>Debra Ann Williams</u>   |  |   | 4. DATE OF DEATH<br>Month Day Year<br><u>2-10-59</u>  |
| 5. SEX<br><u>Female</u>   | 6. COLOR OR RACE<br><u>Colored</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>8-12-55</u>  |
| 9. AGE (In years last birthday)<br><u>3</u>   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>None</u>   | 11. BIRTHPLACE (City and state or country)<br><u>St. Louis, Mo.</u>                                 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>None</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>None</u>  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |
| 13a. FATHER'S NAME<br><u>Limmie (nm) Williams</u>   |  | 13b. MOTHER'S MAIDEN NAME<br><u>Yolanda McGrudger</u>   | 14. NAME OF HUSBAND OR WIFE<br><u>Single</u>  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u>  |  | 16. SOCIAL SECURITY NO.<br><u>None</u>  | 17. INFORMANT<br><u>Helen Nesslein-500 S. Kingshighway</u>  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Aspiration with air way obstruction</u>                                       |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>30 min.</u>  |
| DUE TO (b) <u>Diffuse cortical atrophy</u>  |  |   | <u>life</u>   |
| DUE TO (c) <u>Hydrocephalus, severe</u>   |  |   | <u>life</u>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><u>752X</u>  |  |   | 19. WAS AUTOPSY PERFORMED?<br>1 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT <input checked="" 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<br>Hour Month, Day, Year<br>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>D. O. A. 2-10-59 - 9:30pm</u> and last saw her alive on _____<br>Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated. |  |   |   |
| 22a. SIGNATURE (Degree or title)<br><u>Richard Harty, M.D.</u>  |  | 22b. ADDRESS<br><u>500 S. Kingshighway</u>  | 22c. DATE SIGNED<br><u>2-11-59</u>  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   | 23b. DATE<br><u>2/13/59</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Greenwood</u>  | 23d. LOCATION (City, town, or county) (State)<br><u>St. Louis, County Missouri</u>                  |
| 24. FUNERAL DIRECTOR<br><u>Ellis Funeral Home, 2820 Stoddard St.</u>  |  | 25. DATE RECD. BY LOCAL REG.<br><u>FEB 13 '59</u>   | 26. REGISTRAR'S SIGNATURE<br><u>Richard Harty, M.D.</u>   |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

MEDICAL CERTIFICATION

*Embalsmer's Statement on Reverse Side*

*71 511*

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 *Fulton E. Dick*

Licensed Embalmer No. *4198*  
P. O. Address *F. H. Haines*

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.