Health, & Welfare Public Service

300
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-015959
STATE FILE NUMBER

FILED MAY 1 1959 Registration District No. ..... Primary Registration District No. ..... Registrar's No. 2 2784

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) ST.LOUIS,MO. Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) ST.LOUIS CITY HOSP. #1. Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
b. COUNTY
c. CITY OR TOWN ST.LOUIS,MO. Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location) 3030 A THOMAS Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First BABY Middle BOY Last WILLIAMS

4. DATE OF DEATH Month MAR. Day 8, Year 1959

5. SEX MALE
6. COLOR OR RACE NEGRO
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 3/8/59
9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. 50

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none
10b. KIND OF BUSINESS OR INDUSTRY none
11. BIRTHPLACE (City and state or country) ST.LOUIS,MO.
12. CITIZEN OF WHAT COUNTRY? US.A.

13a. FATHER'S NAME UNKNOWN
13b. MOTHER'S MAIDEN NAME RUTHIE WILLIAMS
14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) none
16. SOCIAL SECURITY NO. none
17. INFORMANT Address ST.LOUIS CITY HOSP. #1.

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) Atelectasis
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) (Congenital)
DUE TO (c) 762.0
INTERVAL BETWEEN ONSET AND DEATH

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 ☒ NO ☐

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 3/8/59, to 3/8/59 and last saw her/him alive on 3/8/59
Death occurred at 4:25 P.M m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Michael S Pozsgay, MD
22b. ADDRESS 1515 LAFAYETTE AVE
22c. DATE SIGNED 3/9/59

23a. BURIAL, CREMATION, REMOVAL (Specify)
23b. DATE 3-31-59
23c. NAME OF CEMETERY OR CREMATORY Anatomical Board
23d. LOCATION (City, town, or county) (State) St. Louis, Mo.

24. FUNERAL DIRECTOR ADDRESS Rowland-Aker 4104 Manchester
25. DATE RECD. BY LOCAL REG. MAR 19 '59
26. REGISTRAR'S SIGNATURE Hand Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 .....

Licensed Embalmer No. .....

P. O. Address .....

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.