MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS DEC 12 1960

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STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 3325

DOCUMENT

1. PLACE OF DEATH
a. COUNTY: St. Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Clayton — Length of stay in Ib: DOA
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: St. Louis County Hospital — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: St. Louis
c. CITY OR TOWN: Overland — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 3110 Chaucer — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: Dennis Middle: Ray Last: Williams
4. DATE OF DEATH: Month: November Day: 14 Year: 1960
5. SEX: Male
6. COLOR OR RACE: White
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 5/22/1959
9. AGE (last birthday) — IF UNDER 1 YEAR: Months: 17 Days: 23 — IF UNDER 24 HR: Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (City and state or country): Webb City, Mo.
12. CITIZEN OF WHAT COUNTRY: U.S.
13a. FATHER'S NAME: John Williams
13b. MOTHER'S MAIDEN NAME: Ruby Smith
14. NAME OF HUSBAND OR WIFE: None
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT: John Williams, Address: Webb City, Mo.

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): Pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: 1 hr
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Atresia of pulmonary artery
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

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 5-22-59, to 8-15-60 and last saw him alive on 8-15-60
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: W. F. W. Forbes (Degree or title): D.O.
22b. ADDRESS: 106 So. Main, Webb City, Mo
22c. DATE SIGNED: 11-30-60

BY AFFIDAVIT OF

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 11-15-60
23c. NAME OF CEMETERY OR CREMATORY: Loc A L
23d. LOCATION (City, town, or county) (State): Webb City, Mo.
24. FUNERAL DIRECTOR ADDRESS: Albert H. Hoppe, Inc., 4700 Washington Blvd.
25. DATE RECD. BY LOCAL REG.: 11-15-60
26. REGISTRAR'S SIGNATURE: John C. Murphy M.D.

(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

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Harvey Frahl

Licensed Embalmer No. 4596

P. O. Address St Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co
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.