

20171

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED JUL 15 1949

BIRTH NO. _____ REG. DIST. NO. 184 PRIMARY REG. DIST. NO. 3038 Registrar's No. 189

1. PLACE OF DEATH a. COUNTY <u>Linn</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Linn</u>					
b. CITY (If outside corporate limits, write RURAL and give township) <u>Brookfield</u>		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) <u>Brookfield</u>		5			
d. FULL NAME OF HOSPITAL OR INSTITUTION				d. STREET ADDRESS (If rural, give location) <u>313 Nichols</u>					
3. NAME OF DECEASED a. (First) <u>Robert</u> b. (Middle) <u>Williams</u> c. (Last) <u>Williams</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>June 29 1949</u>						
5. SEX <u>M-F-Negro</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>June 30 1889</u>			
9. AGE (In years last birthday) <u>59</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS' OR INDUSTRY <u>Labor</u>		11. BIRTHPLACE (State or foreign country) <u>Salisbury Mo</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>Richard Williams</u>		13b. MOTHER'S MAIDEN NAME <u>Jane Ellison</u>		14. NAME OF HUSBAND OR WIFE <u>Pearl Williams</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>437</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Pearl Williams</u> ADDRESS _____					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Hypertensive Cardiovascular Disease</u>				DUPLICATE (b) <u>General arteriosclerosis</u>				<u>7 years</u>	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.				DUPLICATE (c) _____				<u>13 years</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Cardiac asthma</u>								<u>44 ex</u>	
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR					
22. I hereby certify that I attended the deceased from <u>June 29, 1949</u> , to <u>June 29, 1949</u> ; that I last saw the deceased alive on <u>June 29, 1949</u> , and that death occurred at <u>2:22</u> a.m., from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>Ralph W. Robinson M.D.</u>				23b. ADDRESS <u>2115 1/2 Brookfield Mo</u>		23c. DATE SIGNED <u>7/1/49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>July 2</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill</u>		24d. LOCATION (City, town, or county) (State) <u>Brookfield Mo</u>			
DATE REC'D BY LOCAL REG. <u>7-2-49</u>		REGISTRAR'S SIGNATURE <u>A. B. Crivian</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Norman L. ...</u>		ADDRESS _____			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING BLACK INK—MAKE A PERMANENT RECORD



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.

Signed James B M Clelland

Signed.....

Student Embalmer

Licensed Embalmer No. 4230

P. O. Address Brockfield,

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.