

FILED DEC 16 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

42233  
State File No.

BIRTH NO. 124 REG. DIST. NO. 316 PRIMARY REG. DIST. NO. 6075 Registrar's No. 435

1. PLACE OF DEATH a. COUNTY <u>St. Francois</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Dunklin</u>	
b. CITY (If outside corporate limits, write RURAL and give town) <u>Farmington</u> TOWN <u>RURAL</u> St. Francois		c. CITY (If outside corporate limits, write RURAL and give township) <u>St. Francois</u> OR TOWN <u>Kennett</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Missouri State Hospital No. 4</u>		d. STREET ADDRESS (If rural, give location) <u>Unknown</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>MOLLIE</u>		b. (Middle) <u>WILLIAMS</u>	
c. (Last) <u>WILLIAMS</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 15, 1949</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Oct. 23, 1873</u>
9. AGE (In years last birthday) <u>76</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>22</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Cape Girardeau County, Mo.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Frank Moore</u>	
13b. MOTHER'S MAIDEN NAME <u>Eveline James</u>		14. NAME OF HUSBAND OR WIFE <u>Ben F. Williams</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Records State Hospital No. 4, Farmington, Mo.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Terminal pneumonia</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Senility</u>  DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Senile Psychosis and fractured left femur.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Accident</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, public place, etc.) <u>Hospital ward.</u>	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Farmington</u> <u>St. Francois</u> <u>Mo.</u>		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>6-17-49</u>	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Slipped on ward floor and fell, fracturing left femur.</u>	
22. I hereby certify that I attended the deceased from <u>June 17, 1949</u> , to <u>Nov. 15, 1949</u> , that I last saw the deceased alive on <u>Nov. 15, 1949</u> , and that death occurred at <u>5:00A.M.</u> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <i>[Signature]</i>		23b. ADDRESS <u>State Hospital No. 4, Farmington, Mo.</u>	
23c. DATE SIGNED <u>11-17-49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>11-16-49</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>Portageville</u>		24d. LOCATION (City, town, or county) (State) <u>Portageville, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>Dec. 4, 1949</u>		REGISTRAR'S SIGNATURE <i>[Signature]</i>	
25. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i>		ADDRESS <u>H.S. Smith Funeral Home, Caruthersville, Mo.</u>	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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RECORDED 12-12-49  
Sanitary Health Officer No. 4  
Sanitary File Number 1249-1630  
Date Filed

**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 .....  
Student Embalmer

Signed Paul H. Dwyer

Licensed Embalmer No. 4120

P. O. Address Farmington N.H.

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