

FILED FEB 20 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 5377

600
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BIRTH NO. _____ REG. DIST. NO. 192 PRIMARY REG. DIST. NO. 5718 Registrar's No. 8

1. PLACE OF DEATH a. COUNTY McDonald County		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY McDonald	
b. CITY OR TOWN Rt. 1 Southwest City		c. CITY OR TOWN Rural Southwest City	
c. LENGTH OF STAY (in this place) 30 yrs.		d. STREET ADDRESS (If rural, give location) Rural Greenwood Community	
d. FULL NAME OF HOSPITAL OR INSTITUTION None		4. DATE OF DEATH (Month) (Day) (Year) 1-1-50	
3. NAME OF DECEASED (Type or Print) a. (First) Emma b. (Middle) E. c. (Last) Williams		5. SEX Female	
6. COLOR OR RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	
8. DATE OF BIRTH 3-25-1861		9. AGE (In years last birthday) 88 IF UNDER 1 YEAR Months 9 IF UNDER 28 Hrs. 6 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life (even if retired)) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Penn. State		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME W. Jackson		13b. MOTHER'S MAIDEN NAME J. Bixby	
14. NAME OF HUSBAND OR WIFE James J. Williams		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Minnie Pollen ADDRESS _____	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 3 days	
ANTECEDENT CAUSES Hypertensive Heart Disease		DUE TO (a) _____ (b) _____ (c) _____	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		II. OTHER SIGNIFICANT CONDITIONS Recent femur fracture	
21. CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) fractured femur at home		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Southwest City, McDonald Co., Mo.	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 9-21-46 P.M.	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? fall going to toilet	
22. I hereby certify that I attended the deceased from Jan 1, 1933 , to 1-1-50 , that I last saw the deceased alive on 12-31, 1950 , and that death occurred at 6:50 P.M. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) R. S. Varnad, M.D.		23b. ADDRESS Southwest City, Mo.	
23c. DATE SIGNED 2-7-50		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE 1-3-50		24c. NAME OF CEMETERY OR CREMATORY Southwest City	
24d. LOCATION (City, town, or county) (State) Southwest City Mo.		DATE REC'D BY LOCAL REG. 2-8-50	
REGISTRAR'S SIGNATURE Marye Humphrey		423	
25. FUNERAL DIRECTOR'S SIGNATURE M. Humphrey		ADDRESS 1262 Ma	

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

RECEIVED FEB 16 1950
District Health Office No. 6,
District File Number 250-223
Date Filed 2-15-50

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 W. M. Humphrey Jr.

Signed
Student Embalmer

Licensed Embalmer No. 4708

P. O. Address Noel, Mo

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.