

FILED MAY 6 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 14234

BIRTH NO. _____		REG. DIST. NO. 298		PRIMARY REG. DIST. NO. 4448		Registrar's No. 11	
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).			
a. COUNTY Ray		b. CITY (If outside corporate limits, write RURAL and give township) Lawson		a. STATE Missouri		b. COUNTY Ray	
c. LENGTH OF STAY (in this place) 9 years		c. CITY (If outside corporate limits, write RURAL and give township) Lawson		c. CITY (If outside corporate limits, write RURAL and give township) Lawson		0095	
d. FULL NAME OF HOSPITAL OR INSTITUTION				d. STREET ADDRESS (If rural, give location) D			
3. NAME OF DECEASED			4. DATE OF DEATH			5. SEX	
a. (First) CHARLES	b. (Middle) OLIVER	c. (Last) WILLIAMS	Month April	Day 25	Year 1950	Male	White
6. COLOR OR RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)	
White		Married		June 14 1882		67	10 11
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Railroad Laborer		Stationary Fireman		Princeton Missouri		U.S.A.	
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME		14. NAME OF HUSBAND OR WIFE			
John Henry Williams		Pauline Lovell		Corra Bell Williams			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS			
No		486-12-6065		Mrs Cora Bell Williams Lawson Mo			
18. CAUSE OF DEATH		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
Enter only one cause per line for (a), (b), and (c)		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				10 days	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		Acute Uremia, Acute Prostatitis				3 wks	
		ANTECEDENT CAUSES					
		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.					
		DUE TO (b) Influenza,					
		DUE TO (c)					
		II. OTHER SIGNIFICANT CONDITIONS				481X	
		Conditions contributing to the death but not related to the disease or condition causing death.					
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)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. CITY, TOWN, OR TOWNSHIP (COUNTY) (STATE)			
				Lawson Ray Mo			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)		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 April 15, 1950, to April 25, 1950, that I last saw the deceased alive on April 24, 1950, and that death occurred at 9:15 A.M., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title)				23b. ADDRESS		23c. DATE SIGNED	
Clatus Buehner M.D.				Lawson Mo		April 25 1950	
24a. BURIAL CREMATION-REMOVAL (Specify)		24b. DATE		24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State)	
Burial		April 27 1950		Lawson		Lawson Mo	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Apr 27 1950		Mrs Raymond Lovell		364 Jarman		Richard Lawson, Mo.	
(Licensed Embalmer's Statement on Reverse Side)							

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

896
6

Public Health
District Health Officer No. 19
District File Number
Date Filed

MAY 5

5/5/50
MAY 6 1 1950

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 *Lindell K. Jarman*

Licensed Embalmer No. *4589*

P. O. Address *Exelior Springs*

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.