

FILED DEC 4 1950

# STANDARD CERTIFICATE OF DEATH

State File No. **36274**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. **1330**

**1. PLACE OF DEATH**  
 a. COUNTY **Buchanan**  
 b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN **St. Joseph**  
 c. LENGTH OF STAY (in this place) **25 yrs.**  
 d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) **Missouri Methodist Hosp.**

**2. USUAL RESIDENCE** (Where deceased lived. If institution: residence before admission).  
 a. STATE **Missouri**  
 b. COUNTY **Buchanan**  
 c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN **St. Joseph**  
 d. STREET ADDRESS (If rural, give location) **226 Ohio St.**

**3. NAME OF DECEASED**  
 a. (First) **ILA**  
 b. (Middle) \_\_\_\_\_  
 c. (Last) **WILLIAMS**  
 4. DATE OF DEATH (Month) **11** (Day) **22** (Year) **1950**

**5. SEX** **Female** **6. COLOR OR RACE** **White** **7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED** **Married**  
**8. DATE OF BIRTH** **1-7-1902** **9. AGE** (In years last birthday) **48** **IF UNDER 1 YEAR** Months \_\_\_\_\_ Days \_\_\_\_\_ **IF UNDER 24 HRS.** Hours \_\_\_\_\_ Min. \_\_\_\_\_

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired) **Housewife** **10b. KIND OF BUSINESS OR INDUSTRY** **Home** **11. BIRTHPLACE** (State or foreign country) **Cordon, Iowa /** **12. CITIZEN OF WHAT COUNTRY?** **USA**

**13a. FATHER'S NAME** **Edward Ruark** **13b. MOTHER'S MAIDEN NAME** **Unknown** **14. NAME OF HUSBAND OR WIFE** **Joseph 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.** **493-18-6290** **17. INFORMANT'S SIGNATURE OR NAME** **Joe Williams, 226 Ohio St., City.** 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, asthma, etc. It means the disease, injury, or complication which caused death.  
**I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH\*** (a) **Carcinoma, generalized** **INTERVAL BETWEEN ONSET AND DEATH** **6 mo**  
**ANTECEDENT CAUSES**  
 Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. **DUE TO (b)** **Carcinoma, cervix uteri** **18 mo.**  
**DUE TO (c)** \_\_\_\_\_  
**II. OTHER SIGNIFICANT CONDITIONS**  
 Conditions contributing to the death but not related to the disease or condition causing death. **Secondary anemia**  
**Broncho-pneumonia** **17/1X**

**19a. DATE OF OPERATION** **9-27-49** **19b. MAJOR FINDINGS OF OPERATION** **Complete hysterectomy - adenocarcinoma** **20. AUTOPSY?** YES  NO

**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) \_\_\_\_\_ **21e. INJURY OCCURRED** WHILE AT WORK  NOT WHILE AT WORK  **21f. HOW DID INJURY OCCUR?** \_\_\_\_\_

**22. I hereby certify that I attended the deceased from** **7-11, 1949**, to **11-22, 1950**, that I last saw the deceased alive on **11-22, 1950**, and that death occurred at **10:00 P.M.**, from the causes and on the date stated above.

**23a. SIGNATURE** **D. Grant M.D.** (Degree or title) **23b. ADDRESS** **St. Joseph Mo** **23c. DATE SIGNED** **11-24-50**

**24a. BURIAL, CREMATION, REMOVAL** **Burial** **24b. DATE** **11-25-1950** **24c. NAME OF CEMETERY OR CREMATORY** **Memorial Park** **24d. LOCATION** (City, town, or county) (State) **St. Joseph, Mo.**

**DATE REC'D BY LOCAL REG.** **Nov. 29, 1950** **REGISTRAR'S SIGNATURE** **Carl C. Castle** **25. FUNERAL DIRECTOR'S SIGNATURE** **John B. Rupp** **ADDRESS** **St. Joseph, Mo.**

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

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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 \_\_\_\_\_

working under my personal supervision.

Student Embalmer No. ....

Signed \_\_\_\_\_

*John E. Rupp*  
Licensed Embalmer No. 3986

Signed.....  
Student Embalmer

P. O. Address, St Joseph

**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.