

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

4127

State File No. \_\_\_\_\_

FILED MAR 6 1951

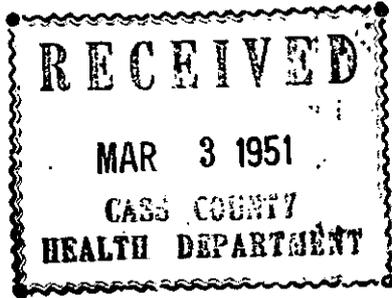
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BIRTH NO. _____		REG. DIST. NO. <u>59</u>	PRIMARY REG. DIST. NO. <u>5233</u>	Registrar's No. <u>25</u>
1. PLACE OF DEATH a. COUNTY <u>CASS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>CASS</u>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>RURAL - WEST DOLAN</u>		c. LENGTH OF STAY (In this place) <u>20 YRS</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>RURAL WEST DOLAN</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>WEST DOLAN</u>		d. STREET ADDRESS (If rural, give location) <u>WEST DOLAN</u>		
3. NAME OF DECEASED (Type or Print) a. (First) <u>THOMAS</u> b. (Middle) <u>J.</u> c. (Last) <u>WILLIAMS</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>FEB. 26-1951</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>JULY 26, 1865</u>	9. AGE (In years last birthday) <u>85</u> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 2 HRS: Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMER</u>	11. BIRTHPLACE - (State or foreign country) <u>MATON - ILLINOIS</u>	12. CITIZENRY OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>DAVID J. WILLIAMS</u>		13b. MOTHER'S MAIDEN NAME <u>MARGARET CASH</u>	14. NAME OF HUSBAND OR WIFE <u>LILLIE KARR-WILLIAMS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT'S SIGNATURE OR NAME <u>MRS LILLIE WILLIAMS - WESTLINE</u> ADDRESS _____	
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, asthma, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH <u>24 HRS</u>  <u>331X</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Recurrent Cerebral Hemorrhage</u>			
	ANTECEDENT CAUSES  Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  DUE TO (c) _____			
II. OTHER SIGNIFICANT CONDITIONS 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) _____		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) _____	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>Feb 24, 1951</u> , to <u>Feb 26, 1951</u> , that I last saw the deceased alive on <u>Feb 26, 1951</u> , and that death occurred at <u>10:30 p.m.</u> , from the causes and on the date stated above.				
23a. SIGNATURE (Degree or title) <u>Paul Ostroff M.D.</u>		23b. ADDRESS <u>Drexel Mo</u>		23c. DATE SIGNED <u>2/27-51</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>2-28-51</u>	24c. NAME OF CEMETERY OR CREMATORY <u>GLENWILD</u>	24d. LOCATION (City, town, or county) (State) <u>WESTLINE - CASS - MISSOURI</u>	
DATE REC'D BY LOCAL REG. <u>2-27-51</u>	REGISTRAR'S SIGNATURE <u>Laura J. Jones</u>	51	25. FUNERAL DIRECTOR'S SIGNATURE <u>Walter S. Runyan</u> ADDRESS <u>Fountain Springs, Kas.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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



OCT 16 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 \_\_\_\_\_

working under my personal supervision.

Student Embalmer No. ....

Signed

*Walter B. Ruygan*

Signed.....

Student Embalmer

Licensed Embalmer No. *3222*

P. O. Address *Louisburg Kansas*

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.