

FILED JAN 20 1953

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 2503

|                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                          |                              |                                                                                                                             |             |                                                                                  |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|-----------------------------------------------------------------------------------------------------------------------------|-------------|----------------------------------------------------------------------------------|--|
| BIRTH NO. _____                                                                                                                                                                                                               |  | REG. DIST. NO. 274                                                                                                                                                                                                                                                                                                                                                                                                       |                              | PRIMARY REG. DIST. NO. 3052                                                                                                 |             | Registrar's No. 16                                                               |  |
| 1. PLACE OF DEATH<br>a. COUNTY Pettis                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                                                                                                                                          |                              | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>a. STATE Missouri b. COUNTY Pettis |             |                                                                                  |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Sedalia                                                                                                                                          |  | c. LENGTH OF STAY (In this place) 1da                                                                                                                                                                                                                                                                                                                                                                                    |                              | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Sedalia                                        |             | 1884                                                                             |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Bothwell Hospital                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                                                                                                                                          |                              | d. STREET ADDRESS (If rural, give location) 235 So. Quincy                                                                  |             |                                                                                  |  |
| 3. NAME OF DECEASED<br>(Type or Print) ASA                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                                                                                                                                          | a. (First) ASA               |                                                                                                                             |             | b. (Middle) WILLIAMS                                                             |  |
| c. (Last) WILLIAMS                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                                                                                                                          | 4. DATE OF DEATH Jan 13 1953 |                                                                                                                             | 5. SEX Male |                                                                                  |  |
| 6. COLOR OR RACE White                                                                                                                                                                                                        |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed 2                                                                                                                                                                                                                                                                                                                                                         |                              | 8. DATE OF BIRTH Feb-3-1874                                                                                                 |             | 9. AGE (In years last birthday) 78                                               |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired                                                                                                                           |  | 10b. KIND OF BUSINESS OR INDUSTRY Carpenter                                                                                                                                                                                                                                                                                                                                                                              |                              | 11. BIRTHPLACE (City and State or Foreign Country) Benton Co. Mo.                                                           |             | 12. CITIZEN OF WHAT COUNTRY? U.S.A                                               |  |
| 13a. FATHER'S NAME Samuel A Williams                                                                                                                                                                                          |  | 13b. MOTHER'S MAIDEN NAME Mary Cathy                                                                                                                                                                                                                                                                                                                                                                                     |                              | 14. NAME OF HUSBAND OR WIFE Mary A. Williams                                                                                |             |                                                                                  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no                                                                                                                   |  | 16. SOCIAL SECURITY NO. 491-07-5183                                                                                                                                                                                                                                                                                                                                                                                      |                              | 17. INFORMANT'S SIGNATURE OR NAME Mrs. Mae Kirby                                                                            |             |                                                                                  |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. |  | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ac. Cardiac Dilatation<br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) Influenza - Pneumonia<br>DUE TO (c)<br>II. OTHER SIGNIFICANT CONDITIONS<br>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)                                                                             |             | 480X                                                                             |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour)                                                                                                                                                                               |  | 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 Jan 3, 1953, to Jan 13, 1953, that I last saw the deceased alive on 1-13, 1953, and that death occurred at 2 A.M., from the causes and on the date stated above.       |  |                                                                                                                                                                                                                                                                                                                                                                                                                          |                              |                                                                                                                             |             |                                                                                  |  |
| 23a. SIGNATURE W. T. Boyer, M.D. (Degree or title)                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                                                                                                                          |                              | 23b. ADDRESS Sedalia, Mo.                                                                                                   |             | 23c. DATE SIGNED 1-14-53                                                         |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial                                                                                                                                                                              |  | 24b. DATE 1-15-53                                                                                                                                                                                                                                                                                                                                                                                                        |                              | 24c. NAME OF CEMETERY OR CREMATORY Memorial Park                                                                            |             | 24d. LOCATION (City, town, or county) (State) Sedalia Mo.                        |  |
| DATE REC'D BY LOCAL REG. 1-15-53                                                                                                                                                                                              |  | REGISTRAR'S SIGNATURE A. J. Campbell M.D. (Licensed Embalmer) Deputy                                                                                                                                                                                                                                                                                                                                                     |                              | 25. FUNERAL DIRECTOR'S SIGNATURE M. Laughlin Bros                                                                           |             | ADDRESS Sedalia                                                                  |  |

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

204  
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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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed \_\_\_\_\_

*H.P.M. Casey*

Licensed Embalmer No. 3153

P. O. Address Sedalia 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.