

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

1140

**FRIED AUG 24 1953**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 376 PRIMARY REG. DIST. NO. 6282 Registrar's No. 11

1. PLACE OF DEATH a. COUNTY <u>Wright</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Wright</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Norwood, Clark Twp.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Norwood, Clark Twp.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>NORTH OF NORWOOD, MO.</u>		d. STREET ADDRESS (If rural, give location) <u>1140</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>James</u>	b. (Middle) <u>Williams</u>	c. (Last) <u>Williams</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Aug-24-53</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>Feb. 28, 1873</u>	9. AGE (In years) (Months) (Days) <u>80 5 13</u>	# UNDER 18 MRS. Hours Mfn.
--------------------	-------------------------------	---	---------------------------------------	--	----------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BOILERMAKER</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>FARMER</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>CHICAGO ILL.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
--	---	--	--

13a. FATHER'S NAME <u>JAMES WILLIAMS SR.</u>	13b. MOTHER'S MAIDEN NAME <u>MARY ANN UNKNOWN LAST NAME</u>	14. NAME OF HUSBAND OR WIFE <u>EVA MAE. MAXON</u>
--	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>552-30-4733</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Eva Mae Williams</u>	ADDRESS <u>Norwood Mo</u>
--	--	---	---------------------------

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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma of Liver</u>		
	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 <u>1561</u>	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) (m.)	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 June 15, 1953 to Aug 11, 1953, that I last saw the deceased alive on Aug 10, 1953, and that death occurred at 1:15 A.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Seldon W. Chambers MD</u>	23b. ADDRESS <u>W. Home, Mo</u>	23c. DATE SIGNED <u>8-15-53</u>
---	---------------------------------	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>AUG. 14-53</u>	24c. NAME OF CEMETERY OR CREMATORY <u>THOMAS</u>	24d. LOCATION (City, town, or county) (State) <u>NORWOOD 170.</u>
---	-----------------------------	--	---

DATE REC'D BY LOCAL REG. <u>Aug 15-53</u>	REGISTRAR'S SIGNATURE <u>Mrs A.R. Warshaw</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Barber</u>	ADDRESS <u>W. Home</u>
---	---	---	------------------------

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

RECEIVED AUG 18 1953  
WRIGHT CO. HEALTH DEPT.  
County File Number 853-112  
Date Filed 8-22-53

SEP 25 1953

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 *R. W. Barber*

Licensed Embalmer No. 3848

P. O. Address *City, Iowa, Ia*

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.