

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **9753**

FILED APR. 6 1954 BIRTH NO. _____ REG. DIST. NO. **296** PRIMARY REG. DIST. NO. **4445** Registrar's No. **2**

1. PLACE OF DEATH a. COUNTY RAY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY Ray	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Ornick		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Ornick	
c. LENGTH OF STAY (in this place) LIFE		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION HOME			
3. NAME OF DECEASED (Type or Print) a. (First) FRED		b. (Middle) T. c. (Last) WILLIAMS	
4. DATE OF DEATH (Month) (Day) (Year) 3 31 54			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Jan. 19, 1890
9. AGE (In years last birthday) 64		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) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMING	
11. BIRTHPLACE (City and State or Foreign Country) Ornick, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME James Williams		13b. MOTHER'S MAIDEN NAME Nettie Rinmer	
14. NAME OF HUSBAND OR WIFE Nellie Stevinson			
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. _____	
17. INFORMANT'S SIGNATURE OR NAME Eva Ruth Sandstrom		ADDRESS Ornick, Mo.	
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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Embolism ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chronic Nephritis 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 592 X	
20. AUTOPSY? YES <input type="checkbox"/> NO <input 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)		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 11-14-53 , 19____, to 3-31-54 , 19____, that I last saw the deceased alive on 3-31-54 , 19____, and that death occurred at 4:45 P. M. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) D. G. F. Simmons, M.D.		23b. ADDRESS Ornick, Mo.	
23c. DATE SIGNED 4-2-54			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 4-2-54	
24c. NAME OF CEMETERY OR CREMATORY South Point		24d. LOCATION (City, town, or county) (State) Ornick, Mo.	
DATE REC'D BY LOCAL REG. 4-5-54		REGISTRAR'S SIGNATURE Helen Larkin	
25. FUNERAL DIRECTOR'S SIGNATURE B.W. Good		ADDRESS Ornick, Mo.	

(Licensed Embalmer's Statement on Reverse Side)

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

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 *Harold J. Taylor*

Licensed Embalmer No. 4534

P. O. Address Liberty

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.