

FILED JUL 26 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **23602**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **182** PRIMARY REG. DIST. NO. **5679** Registrar's No. **16**

1. PLACE OF DEATH a. COUNTY <b>LINN</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE <b>MISSOURI</b> b. COUNTY <b>LINN</b>	
b. CITY (If outside corporate limits, write RURAL and give town or township) <b>BAKER TWP</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>BAKER TWP</b>	
c. LENGTH OF STAY (in this place) <b>35 YRS</b>		d. STREET ADDRESS (If rural, give location) <b>RFD #2 ST. CATHERINE</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>RFD #2, ST. CATHERINE</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>DANIEL</b> b. (Middle) <b>DALE</b> c. (Last) <b>WILLIAMS</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>JULY 20, 1954</b>		
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5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>N.M.</b>	8. DATE OF BIRTH <b>DEC. 7, 1918</b>	9. AGE (In years last birthday) <b>35</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN FARM</b>		11. BIRTHPLACE (State or foreign country) <b>LINN Co. MISSOURI</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
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13a. FATHER'S NAME <b>HARLEY G. WILLIAMS</b>		13b. MOTHER'S MAIDEN NAME <b>ESTHER HOLMLUND</b>		14. NAME OF HUSBAND OR WIFE _____			
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT'S SIGNATURE OR NAME <b>HARLEY G. WILLIAMS, ST. CATHERINE, Mo.</b>				ADDRESS _____	
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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) <b>Heat Exhaustion</b>						INTERVAL BETWEEN ONSET AND DEATH	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Dehydration</b>							
		DUE TO (c) <b>Adrenal Insufficiency</b>						<b>6 wks.</b>	
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							

19a. DATE OF OPERATION <b>None</b>		19b. MAJOR FINDINGS OF OPERATION _____						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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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) _____	
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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? _____			
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22. I hereby certify that I attended the deceased from **July 1<sup>st</sup>**, 19**54**, to **July 20**, 19**54**, that I last saw the deceased alive on **July 19**, 19**54**, and that death occurred at **3:30 pm.**, from the causes and on the date stated above.

23a. SIGNATURE <b>R. D. Robinson M.D.</b> (Degree or title) <b>M.D.</b>		23b. ADDRESS <b>211 Linn Boulevard Mo</b>		23c. DATE SIGNED <b>7/21/54</b>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24b. DATE <b>JULY 22, 1954</b>		24c. NAME OF CEMETERY OR CREMATORY <b>PLEASANT GROVE</b>		24d. LOCATION (City, town, or county) (State) <b>BUCKLIN, Mo</b>	
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DATE REC'D BY LOCAL REG. <b>July 29-1954</b>		REGISTRAR'S SIGNATURE <b>Mrs. Biddie Kelley</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>WRIGHT FUNERAL HOME, BROOKFIELD, Mo</b>				ADDRESS _____	
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(Licensed Embalmer's Statement on Reverse Side)

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 \_\_\_\_\_

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

working under my personal supervision.

Student .....  
Student Embalmer

Signed \_\_\_\_\_

*Harold B. Wright*

Licensed Embalmer No. \_\_\_\_\_

*3718*

P. O. Address \_\_\_\_\_

*Brookfield, 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.