

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED AUG 4 - 1955

State File No. **21318**  
43  
3007 Registrar's No. **432**

BIRTH NO. _____		REG. DIST. NO. <b>43</b>		PRIMARY REG. DIST. NO. _____		Registrar's No. <b>432</b>	
1. PLACE OF DEATH a. COUNTY <b>Butler</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Arkansas</b> b. COUNTY <b>Clay</b> <b>8030</b>			
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <b>Poplar Bluff</b> township) <b>0</b>		c. LENGTH OF STAY (in this place) <b>2 days</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>Pollard</b> <b>8</b>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Dr. Hospital</b>				d. STREET ADDRESS (If rural, give location) <b>Rt. # 1,</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>Edgar</b>			b. (Middle) _____		c. (Last) <b>Williams</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>July 23, 1955</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Sept. 24, 1882</b>		9. AGE (In years last birthday) <b>72</b>	IF UNDER 1 YEAR Months <b>9</b> Days <b>29</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <b>Ft. Smith, Arkansas /</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Francis Williams</b>			13b. MOTHER'S MAIDEN NAME <b>Lula Luton</b>		14. NAME OF HUSBAND OR WIFE <b>Anna Williams</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>		17. INFORMANT'S SIGNATURE OR NAME <b>Fred Williams</b> ADDRESS _____			
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Asphyxiation</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Hypertension, Coronic failure</b> DUE TO (c) <b>Cerebral hemorrhage</b>  II. OTHER SIGNIFICANT CONDITIONS - _____ Conditions contributing to the death but not related to the disease or condition causing death. <b>331X</b>					INTERVAL BETWEEN ONSET AND 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) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <b>7-21</b> , 19 <b>55</b> , to <b>7-23</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>7-23</b> , 19 <b>55</b> , and that death occurred at <b>7:37 p.m.</b> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>William F. Turner M.D.</b>				23b. ADDRESS <b>Poplar Bluff, Mo.</b>		23c. DATE SIGNED <b>7/29/55</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>July 25, 1955</b>	24c. NAME OF CEMETERY OR CREMATORY <b>New Hope Cemetery</b>		24d. LOCATION (City, town, or county) <b>Pollard, Arkansas</b> (State) _____		
DATE REC'D BY LOCAL REG. <b>7/30/55</b>		REGISTRAR'S SIGNATURE <b>J. B. Muehleisen</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>O. L. Mowery</b>		ADDRESS <b>Rector</b>	

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

RECEIVED

AUG 2 1955

BUTLER CO. HEALTH CENTER

FILE No. \_\_\_\_\_

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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 Don McBride

Licensed Embalmer No. 776

P. O. Address Rector, Ark

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.