

FILED MAR 12 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **3934**
Registrar's No. **235**

BIRTH NO. _____ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000**

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

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph		c. LENGTH OF STAY (in this place) most of life	c. CITY OR TOWN St. Joseph
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph's Hospital DOA		e. STREET ADDRESS (If rural, give location) 1802 Scott Street	

3. NAME OF DECEASED (Type or Print) ARCH	a. (First) D.	b. (Middle) WILLIAMS	c. (Last) WILLIAMS	4. DATE OF DEATH (Month) (Day) (Year) Feb. 22, 1956
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5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH March 3, 1901	9. AGE (In years last birthday) 54	IF UNDER 1 YEAR Months	IF UNDER 1 HRS. Hours	IF UNDER 15 MINS. Mins.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attendant	10b. KIND OF BUSINESS OR INDUSTRY State Hosp. #2	11. BIRTHPLACE (City and State or Foreign Country) Platte County, Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Harmon Williams	13b. MOTHER'S MAIDEN NAME Allie McMillien	14. NAME OF HUSBAND OR WIFE Maxine Williams
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) WW II 496-09-2650	17. INFORMANT'S SIGNATURE OR NAME Mrs. Maxine Williams, 1802 Scott-St. Joseph, Mo.	ADDRESS
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Coronary Occlusion		
ANTECEDENT CAUSES	DUE TO (b) signed as an unattended death		
	DUE TO (c) in the city of St. Joseph		
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	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) 4201
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	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 **Jan 2-22, 1956**, to _____, 19____, that I ~~lost~~ ^{have never seen} the deceased ~~again~~ on _____, 19____, and that death occurred at **4:20P. m.**, from the causes and on the date stated above.

23a. SIGNATURE Richard L. Maguin M.D. assistant chief health officer	(Degree or title)	23b. ADDRESS Physician Dejean Bldg. 216, City	23c. DATE SIGNED 2-24-56
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24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE 2/25/1956	24c. NAME OF CEMETERY OR CREMATORY Williams Cemetery	24d. LOCATION (City, town, or county) (State) Dearborn, Missouri
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DATE REC'D BY LOCAL REG. Mar 6, 1956	REGISTRAR'S SIGNATURE Eathan M. Allison	485-1	25. FUNERAL DIRECTOR'S SIGNATURE Heaton-Bourman	ADDRESS St. Joseph, Mo.
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MAR 18 1951

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 Signature of Student Embalmer

Signed *Richard D. Collins*

Licensed Embalmer No. *495*
P. O. Address *219 E. 10th St. Joseph*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.