

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16839

STATE FILE NUMBER

FILED JUN 10 1957

Registration District No. 137 Primary Registration District No. 3023 Registrar's No. 483

Health, Welfare
Public Service

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY Henry			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Clair		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Clinton		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Rural Osceola		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Clinton General Hosp;			Length of stay in lb 28 days		d. STREET ADDRESS Route # (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Phanetta Middle Mae Last Williams			4. DATE OF DEATH June 4, 1957 Month June Day 4 Year 1957		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct; 30, 1886	9. AGE (In years last birthday) 70 IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Carroll County Iowa		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME James R. Bruce			14. MOTHER'S MAIDEN NAME Nancy Copper		
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 P.L. Williams, Osceola Missouri Address _____		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA COLON					INTERVAL BETWEEN ONSET AND DEATH 3 YR
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? 153X YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour _____ Month _____ Day _____ a. m. _____ p. m. _____					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 1954 to 4 June 1957 and last saw her alive on 4 June 1957 Death occurred at 2:15 p. m. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Hugh B. Walker, MD			22b. ADDRESS Clinton Missouri		22c. DATE SIGNED 6/7/57
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/7/57	23c. NAME OF CEMETERY OR CREMATORY Osceola		23d. LOCATION (City, town, or county) (State) Osceola Missouri
24. FUNERAL DIRECTOR Goodrich 2 HOME OSCEOLA MO		ADDRESS		25. DATE RECD. BY LOCAL REG. 6-7-57	26. REGISTRAR'S SIGNATURE Mildred Bigum

(Licensed Embalmer's Statement on Reverse Side)

5210

1951 6 708

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 *J. B. [Signature]*

Licensed Embalmer No. *303*

P. O. Address *Asceola*

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.