

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

57-017907  
Star File No. 75

FILED JUN 14 1957

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 200 PRIMARY REG. DIST. NO. 5733 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <b>MACON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Macon</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>RURAL S. WALNUT</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Rural-S. Walnut Twp.</b>	
c. LENGTH OF STAY (in this place) <b>62yrs.</b>		d. STREET ADDRESS (If rural, give location) <b>3 miles S.E. of Ethel</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>3 miles S.E. of Ethel</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>ANNIE</b> b. (Middle) <b>CATHERINE</b> c. (Last) <b>WILLIAMS</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>JUNE 5 1957</b>		
5. SEX <b>F.</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widow</b>	8. DATE OF BIRTH <b>Jan. 9, 1868</b>	9. AGE (In years last birthday) <b>89</b>	IF UNDER 1 YEAR Months <b>4</b> Days <b>26</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	11. BIRTHPLACE (State or foreign country) <b>SOUTH WALES</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>

13a. FATHER'S NAME <b>William D. Williams</b>	13b. MOTHER'S MAIDEN NAME <b>Margaret Jones</b>	14. NAME OF HUSBAND OR WIFE <b>John J. Williams</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>	16. SOCIAL SECURITY NO. <b>496-42-0821</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Winifred Evans, New Cambria, Mo.</b>

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Medullary Failure</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Sepsis</b> DUE TO (c) <b>Complication of hip fracture</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>6/14/56</b>	19b. MAJOR FINDINGS OF OPERATION <b>Fracture of Hip</b>	20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
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 6/14/, 1956, to 6/5/, 1957, that I last saw the deceased alive on 6/5/, 1957, and that death occurred at 2:55 Pm., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>[Signature]</b>	23b. ADDRESS <b>D.O.A. Knoxville Mo.</b>	23c. DATE SIGNED <b>6-7-57</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>June 7, 1957</b>	24c. NAME OF CEMETERY OR CREMATORY <b>New Cambria Cemetery</b>
		24d. LOCATION (City, town, or county) (State) <b>New Cambria, Mo.</b>

DATE REC'D BY LOCAL REG. <b>6/8/57</b>	REGISTRAR'S SIGNATURE <b>[Signature]</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>[Signature]</b>	ADDRESS <b>New Cambria Mo.</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

County File No. 6-5789  
Date Filed 6.11.57

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.

Signed *H. J. Hilliard*

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. 4819

P. O. Address New Cambria 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.