

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **23443**

FILED AUG 7 1957

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 10 PRIMARY REG. DIST. NO. 3001 Registrar's No. 188

1. PLACE OF DEATH a. COUNTY <b>Audrain</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Callaway</b>	
b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN <b>Mexico</b>		c. LENGTH OF STAY (in this place) <b>30 days</b>	c. CITY OR TOWN <b>Fulton</b>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Audrain Hospital</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or Print) a. (First) <b>NATHAN</b> b. (Middle) <b>Rice</b> c. (Last) <b>WILLIAMSON</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>7-31-57</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>May 9, 1870</b>
9. AGE (In years last birthday) <b>87</b>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Mins. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired State Hosp</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Attendant</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Hams Prairie, Mo.</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A</b>		13a. FATHER'S NAME <b>William Thomas Williamson</b>	
13b. MOTHER'S MAIDEN NAME <b>Sarah Eliz. Mattox</b>		14. NAME OF HUSBAND OR WIFE <b>Mattie</b>	
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 <b>497-16-3195</b>	
17. INFORMANT'S SIGNATURE OR NAME <b>Omer Williamson,</b>		ADDRESS <b>Fulton, Mo</b>	
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>PULMONARY EDEMA</b>  ANTECEDENT CAUSES DUE TO (b) <b>A.S. Heart DISEASE</b> DUE TO (c) <b>Gen. arteriosclerosis</b>  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? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		21. INTERVAL BETWEEN ONSET AND DEATH <b>48 HRS</b> <b>Many years</b>	
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 <b>July 28, 1957</b> , to <b>July 31, 1957</b> that I last saw the deceased alive on <b>July 31, 1957</b> and that death occurred at <b>4:50 p.m.</b> , from the causes and on the date stated above.			
23a. SIGNATURE <b>Edward J. Davis</b> (Degree or title) <b>J.M.D.</b>		23b. ADDRESS <b>209 E Jackson Mexico Mo</b>	
23c. DATE SIGNED <b>7-31-57</b>		24a. BURIAL, CREMATION, REINTERMENT <b>Burial</b>	
24b. DATE <b>Aug. 3, 1957</b>		24c. NAME OF CEMETERY OR CREMATOR <b>Hillcrest</b>	
24d. LOCATION (City, town, or county) <b>Fulton</b> (State) <b>MO</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Wallace Funeral Home, Fulton, Mo</b> ADDRESS _____	
DATE REC'D BY LOCAL REG. <b>Aug 3 1957</b>		REGISTRAR'S SIGNATURE <b>Beneche Neely</b>	

(Licensed Embalmer's Statement on Reverse Side)

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

FORM NO. 10

**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 *Hector R. Masare*

Licensed Embalmer No. *499*

P. O. Address *Fulton, N.Y.*

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.