

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

28850  
STATE FILE NUMBER

FILED SEP 10 1957

Registration District No. 236 Primary Registration District No. 4352 Registrar's No. 63

1. PLACE OF DEATH a. COUNTY <u>Morgan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Morgan</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Versailles</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Moreau Township</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Length of stay in lb	d. STREET ADDRESS <u>4 mi E of Versailles</u>
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First <u>Bill</u>	Middle <u>(Mrd)</u>	Last <u>Williams</u>	Month <u>Aug</u> Day <u>31</u> Year <u>1957</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 11, 1900</u>
10a. USUAL OCCUPATION (Give kind of work done during most of last year if retired) <u>Common Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	11. BIRTHPLACE (City and state or country) <u>Lafayette County, Mo.</u>
13a. FATHER'S NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE	

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) (If yes, give word and dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>491-36-9140</u>	17. INFORMANT Address <u>H. G. Goodman Versailles, Mo.</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ABDOMINAL HEMMORRAGE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u>	

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>DEGENERANCE of LYONNA GUN WEIN</u>	<u>immediate</u>
	DUE TO (c) <u>GUN SHOT PIERCING DEGENERANCE WEIN</u>	<u>immediate</u>
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Justifiable</u>	

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>Gunshot wound by NIGAR Marshall, justifiable</u>
20c. TIME OF INJURY Hour <u>7:15</u> Month <u>Aug</u> Day <u>31</u> Year <u>57</u> p.m.	20d. INJURY OCCURRED WHILE AT WORK <input checked="" 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.) <u>City Street</u>	20f. CITY, TOWN, OR LOCATION <u>Versailles Morgan Mo</u>

21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at <u>7:20 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.	
21a. SIGNATURE <u>Frank D. Dathan</u> (Degree or title) <u>Coroner</u>	21b. ADDRESS <u>Versailles, Mo</u>
21c. DATE SIGNED <u>3-Sept-57</u>	21d. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>3 Sept. 57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Dover Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Dover, Mo.</u>
24. FUNERAL DIRECTOR <u>W. J. Kidwell</u>	ADDRESS <u>Versailles, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>9-5-57</u>	26. REGISTRAR'S SIGNATURE <u>J L Vasth</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

Date of death: \_\_\_\_\_  
 Time of death: \_\_\_\_\_  
 Place of death: \_\_\_\_\_  
 Name of deceased: \_\_\_\_\_  
 Age: \_\_\_\_\_  
 Sex: \_\_\_\_\_  
 Race: \_\_\_\_\_  
 Cause of death: \_\_\_\_\_  
 Manner of death: \_\_\_\_\_  
 Name of physician: \_\_\_\_\_  
 Name of funeral home: \_\_\_\_\_  
 Name of embalmer: \_\_\_\_\_  
 Name of student embalmer: \_\_\_\_\_  
 Name of witness: \_\_\_\_\_  
 Name of witness: \_\_\_\_\_

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 Raymond A. Sticker  
 Licensed Embalmer No. \_\_\_\_\_  
 P. O. Address Versailles, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.

Name of witness: \_\_\_\_\_  
 Name of witness: \_\_\_\_\_