

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **34509**

FILED OCT 14 1957

BIRTH NO. _____		REG. DIST. NO. <u>324</u>		PRIMARY REG. DIST. NO. <u>3022</u>		Registrar's No. <u>185</u>	
1. PLACE OF DEATH a. COUNTY <u>Saline</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Saline</u>			
b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN <u>Marshall</u>		c. LENGTH OF STAY (in this place) <u>9 da.</u>		c. CITY OR TOWN <u>Marshall</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Fitzgibbon Hosp.</u>				e. STREET ADDRESS (If rural, give location) <u>70 Lafayette</u>			
3. NAME OF DECEASED (Type or Print)		a. (First) <u>CHARLES</u>		b. (Middle) <u>WILLIAM</u>		c. (Last) <u>WILLIG</u>	
4. DATE OF DEATH		(Month) <u>Oct.</u>		(Day) <u>11,</u>		(Year) <u>1957</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>		8. DATE OF BIRTH <u>Sept. 30, 1870</u>	
9. AGE (In years last birthday) <u>87</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 10 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Cooper County, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13a. FATHER'S NAME <u>George Willig</u>		13b. MOTHER'S MAIDEN NAME <u>Louise Fox</u>		14. NAME OF HUSBAND OR WIFE <u>Lillie Mae Willig</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give var or dates of service) <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Clarence J. Willig</u> ADDRESS <u>Shackelford, Mo</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <u>Anterograde Heart Disease</u>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Anterograde Heart Disease</u> INTERVAL BETWEEN ONSET AND DEATH _____ ANTECEDENT CAUSES *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ 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? <u>Y</u> YES <input type="checkbox"/> NO <input type="checkbox"/>	
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) (Min.) _____		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 <u>Sept 11, 1957</u> , to <u>Oct 11, 1957</u> , that I last saw the deceased alive on <u>Oct 11, 1957</u> , and that death occurred at <u>8:30 A</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>James A. Reid M.D.</u>				23b. ADDRESS <u>Marshall Mo</u>		23c. DATE SIGNED <u>10-11-57</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>10-13-1957</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Sunset Memorial Gardens</u>		24d. LOCATION (City, town, or county) (State) <u>Marshall, Mo</u>	
DATE REC'D BY LOCAL REG. <u>10-12-57</u>		REGISTRAR'S SIGNATURE <u>Carl J. Reid</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Harry Hershberger</u> ADDRESS <u>Marshall, Mo</u>			

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

OCT 17 1957

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..... *Harry Hershberger*

Licensed Embalmer No... *435*

P. O. Address *Marshall*

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.