

FILED NOV 8 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

36383

STATE FILE NUMBER

Registration District No. 156 Primary Registration District No. 2001 Registrar's No. 615

S. 300  
v. 1-57

1. PLACE OF DEATH a. COUNTY <u>JASPER</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>JASPER</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>JOPLIN</u>		c. CITY OR TOWN <u>JOPLIN</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1816 MOFFET AVE.</u>		d. STREET ADDRESS <u>1816 MOFFET AVE</u>	
Length of stay in lb YRS		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>ROSIE</u> Middle <u>BELLE</u> Last <u>WILLIAMS</u>			4. DATE OF DEATH Month <u>OCT.</u> Day <u>9</u> Year <u>1957</u>		
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5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APR. 12, 1871</u>	9. AGE (In years last birthday) <u>86</u>	10. FUNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	11. IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	11. BIRTHPLACE (City and state or country) <u>JASPER COUNTY, MO.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
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13a. FATHER'S NAME <u>JOHN HATHCOCK</u>	13b. MOTHER'S MAIDEN NAME <u>NANCY MOSS</u>	14. NAME OF HUSBAND OR WIFE <u>CHAS. A. WILLIAMS, DEC 2-6-57</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO.	17. INFORMANT <u>MRS. ROSALIE ANDERSON, 1816 MOFFET</u>
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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>Chronic medullary failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Cerebral arteriosclerosis</u>	<u>3 yrs.</u>
	DUE TO (c) <u>Senility</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>334X</u>		19. WAS AUTOPSY PERFORMED? 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.)
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20c. TIME OF INJURY Hour <u>          </u> Month, Day, Year a.m. <u>          </u> p.m. <u>          </u>	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 <u>          </u> COUNTY <u>          </u> STATE <u>          </u>
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21. I attended the deceased from <u>August 1957</u> to <u>10-9-57</u> and last saw her alive on <u>10-8-57</u> Death occurred at <u>          </u> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>Steve Parker</u> (Degree or title)	22b. ADDRESS <u>521 W. 4th Joplin, Mo.</u>	22c. DATE SIGNED <u>11-1-57</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>10-12-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>DIAMOND CEMETERY;</u>	23d. LOCATION (City, town, or county) (State) <u>DIAMOND, MISSOURI</u>
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24. FUNERAL DIRECTOR <u>STEVE PARKER MORTUARY, JOPLIN, MO.</u>	25. DATE RECD. BY LOCAL REG. <u>11-4-1957</u>	26. REGISTRAR'S SIGNATURE <u>Dove Merriam</u>
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(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

260

Date Filed 5-1-1957  
County File Number

STATE OF MISSISSIPPI  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
MEMPHIS, TENNESSEE

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 *F. M. Jones* \_\_\_\_\_  
Licensed Embalmer No. *2317*

P. O. Address *Jackson, Miss*

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.