

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED OCT 28 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER
37102

Registration District No. 316 Primary Registration District No. 6075 Registrar's No. 323

1. PLACE OF DEATH a. COUNTY St. Francois			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Mississippi		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Francois Twp.		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN Wyatt		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hospital #4		Length of stay in 1b 5y, 6m, 19d	d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MAUDE Middle ANN Last WILLIAMS			4. DATE OF DEATH Month Oct. Day 5 Year 1957		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 19, 1917	9. AGE (In years last birthday) 39 IF UNDER 1 YEAR IF UNDER 24 HRS. Months 9 Days 16 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) New Canton, Illinois	
13. FATHER'S NAME BERT WILLIAMS			14. MOTHER'S MAIDEN NAME LORENE HAMILTON		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Records, State Hospital #4, Farmington, Mo.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary tuberculosis - - - - - revealed by x-ray 4-20-53.					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					002X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Psychosis with other infectious diseases.					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.)			
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____					
20d. INJURY OCCURRED WHILE AT WORK <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 COUNTY STATE	
21. I attended the deceased from Feb. 3, 1952 to Oct. 5, 1957 and last saw her ^{alive} on Oct. 5, 1957 Death occurred at 7:15 p. m. m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>Esther Rudloff</i> (Degree or title)			22b. ADDRESS State Hospital No. 4, Farmington, Mo.		22c. DATE SIGNED 10-5-57
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Oct. 7, 1957	23c. NAME OF CEMETERY OR CREMATORY I.O.O. F. Cemetery		23d. LOCATION (City, town, or county) (State) Charleston, Missouri
24. FUNERAL DIRECTOR Nunnelee Funeral Home, Charleston, Mo.		ADDRESS		25. DATE RECD. BY LOCAL REG. Oct. 5, 1957	26. REGISTRAR'S SIGNATURE <i>Esther Rudloff</i>

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
Licensed Embalmer No. 40

P. O. Address
Farrington

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.