

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

704

FILED FEB 3 1958

STATE FILE NUMBER

Registration District No. 82

Primary Registration District No. 4147

Registrar's No. 16

300
-57

1. PLACE OF DEATH a. COUNTY <u>Cooper</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cooper</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bunceton</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Bunceton</u> 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>Bunceton</u>		Length of stay in lb <u>Life</u>	d. STREET ADDRESS (If outside, give location) <u>No street numbers</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Henry</u> Last <u>Williams</u>			4. DATE OF DEATH Month <u>January</u> Day <u>28</u> Year <u>1958</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</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>Dec. 28, 1862</u>	9. AGE (In years last birthday) <u>95</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Public</u>	11. BIRTHPLACE (City and state or country) <u>Bunceton, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>

13a. FATHER'S NAME <u>Luke Williams</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Armenia Williams</u>	
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. <u>None</u>		17. INFORMANT <u>Lucinda President (Daughter) Bunceton, Mo</u> Address	

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>Acute Circulatory Failure</u>			INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
DUE TO (b) <u>Fulminating Pneumonia</u>			
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>493X</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.) <u>493X</u>		
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.) <u>Bunceton</u>		20f. CITY, TOWN, OR LOCATION <u>Cooper</u>		COUNTY <u>Mo.</u>		STATE	
21. I attended the deceased from <u>8-12-57</u> to <u>1-28-58</u> and last saw him alive on <u>1-16-58</u> Death occurred at <u>home</u> <u>3</u> a. m. on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>Richard W. Callison D.O.</u>					22b. ADDRESS <u>Bunceton, Mo.</u>			22c. DATE SIGNED <u>1-28-58</u>	

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Jan 31, 1958</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bunceton Colored Cemetery</u>		23d. LOCATION (City, town, or county) <u>Bunceton, Missouri</u>		STATE <u>Mo.</u>	
24. FUNERAL DIRECTOR <u>Janece F. Riker, Tipton, Mo.</u>					25. DATE RECD. BY LOCAL REG. <u>1-28-58</u>		26. REGISTRAR'S SIGNATURE <u>W. Hooper</u>		

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Jewell E. Richer*
Licensed Embalmer No. *2466*
P. O. Address *Lipton*

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.