

health, Welfare public service
 300
 1-56
 ATTENTION: No symptoms were listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms were listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

FILED APR 3 1958

58-012499

318

1003

STATE FILE NUMBER

3431

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jefferson			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN DeSoto		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Deaconess Hospital		Length of stay in lb 2 days		d. STREET ADDRESS 603 Fletcher		(If outside, give location) Residence Form Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Bessie Mae Williamson				4. DATE OF DEATH Mar. 21, 1958 Month Day Year			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 1, 1902	9. AGE (In years last birthday) 55	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (City and state or country) DeSoto, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME J. R. Wood				14. MOTHER'S MAIDEN NAME Norwilda Huskey			
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. ?		17. INFORMANT Address Robt. Thompson DeSoto, 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) <i>Cerebral thrombosis</i>						INTERVAL BETWEEN ONSET AND DEATH 4 days	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <i>Arteriosclerotic Vascular Disease?</i>					
		DUE TO (c) <i>332+</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Idiopathic Hemolytic Anemia</i>						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 <i>1953</i> to <i>Mar 21 '58</i> and last saw her alive on <i>3-21-58</i> Death occurred at <i>11:00 p.</i> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <i>C. E. Mueller MD</i>				22b. ADDRESS <i>634 N. Grand Blvd.</i>		22c. DATE SIGNED <i>3-22-58</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>3/24/58</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Woodlawn</i>		23d. LOCATION (City, town, or county) (State) <i>DeSoto Mo.</i>	
24. FUNERAL DIRECTOR <i>J. Lee Mothershead</i>		ADDRESS <i>DeSoto, Mo.</i>		25. DATE RECD. BY LOCAL REG. <i>MAR 25 '58</i>		26. REGISTRAR'S SIGNATURE <i>Carl Smith MD</i>	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *Andrew H. England*

Licensed Embalmer No. *47*

P. O. Address *de Soto*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.