

t. Health,  
, & Welfare  
S. Public  
th Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-033420  
STATE FILE NUMBER

FILED SEP 22 1958 Registration District No. 179 Primary Registration District No. 5667 Registrar's No. 169

5. 300  
v. 1-57

1. PLACE OF DEATH a. COUNTY <b>Lincoln</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St Charles</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Bedford Twp</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>Foristell</b> 0920
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Lincoln Co Mem Hspp 2 Dys</b>		Length of stay in lb	d. STREET ADDRESS (If outside, give location)
Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>Louvenia</b> Middle <b>Williams</b> Last <b>Williams</b>			4. DATE OF DEATH Month <b>Sept</b> Day <b>16</b> Year <b>1958</b>		
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb 10 1867</b>	9. AGE (In years) <b>91</b> (birthday)	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (City and state or country) <b>St Charles CO Mo</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>
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13a. FATHER'S NAME <b>N.E Williams</b>	13b. MOTHER'S MAIDEN NAME <b>Katherine Bowman</b>	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <b>NO</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Bertha Williams Foristell MO</b> Address
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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) <b>Medullary Paralysis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1992</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Generalized Carcinomatosis</b>	
	DUE TO (c) <b>Senile Debility</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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 a.m. p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input checked="" 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
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21. I attended the deceased from Death occurred at <b>3:00</b> on <b>9/16/58</b> and last saw her alive on <b>9/16/58</b> at <b>A</b> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <b>Ronald Carlett</b> (Degree or title)	22b. ADDRESS <b>Troy, Mo</b>	22c. DATE SIGNED <b>9/17/58</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Sept 18 /58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Wright City Cemetery</b>	23d. LOCATION (City, town, or county) <b>Wright City Mo</b> (State)
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24. FUNERAL DIRECTOR <b>Wiegurg Furn &amp; Und CO Wright City</b>	25. DATE RECD. BY LOCAL REG. <b>9-19-58</b>	26. REGISTRAR'S SIGNATURE <b>Charlotte Leek and J. Shafer</b>
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MO (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

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 *Julius J. Nieburg* .....

Licensed Embalmer No. *3866* .....

P. O. Address *Wright City* .....

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.