

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-044798
STATE FILE NUMBER

FILED DEC 19 1958

Registration District No. 181 Primary Registration District No. 4294 Registrar's No. 62

300
1-57

1. PLACE OF DEATH a. COUNTY <u>Lincoln</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lincoln</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Silex</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Silex</u> 0570 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>Home</u>		Length of stay in lb <u>18 yrs.</u>	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 Middle Last <u>William Washington Treadway</u>			4. DATE OF DEATH Month Day Year <u>Dec. 1, 1958</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</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>Sept 14, 1865</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician (M.D.)</u>		9b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years less birthday) <u>73</u> IF UNDER 1 YEAR Months <u>2</u> Days <u>16</u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician (M.D.)</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Pike County, Missouri</u>
12. CITIZEN OF WHAT COUNTRY? <u>US</u>		13. FATHER'S NAME <u>John M. Treadway</u>	
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME <u>Elizabeth Ann Coons</u>	14. NAME OF HUSBAND OR WIFE <u>Ada Treadway</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 Address <u>Leon Gooch Silex, Missouri</u>
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>Bronchopneumonia</u> DUE TO (b) <u>Cerebral Hemorrhage</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>8 years 11 mo.</u>
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Confined to bed for 8 years & 11 months.</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.)	
20c. TIME OF INJURY Hour Month, Day, Year o.m. p.m.		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 COUNTY STATE	
21. I attended the deceased from <u>Nov. 25-58</u> to <u>Dec. 1-58</u> and last saw him alive on <u>Nov. 30-1958</u> Death occurred at <u>3:30 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>R.M. Penn. M.D.</u>		22b. ADDRESS <u>Silex Mo.</u>	
22c. DATE SIGNED <u>12-2-58</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>12-3-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cemetery</u>
23d. LOCATION (City, town, or county) (State) <u>Clarksville, Missouri</u>			
24. FUNERAL DIRECTOR <u>J. O. Kudd Bowling Green, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>12-17-1958</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Clarence Kientz</u>

(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

550

DEC 28 1958

DEC 28 1958

VS OCT 21 1959

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 James O. Mudd

Licensed Embalmer No. 4152

P. O. Address Baltimore, Md.

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.