

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-004434
STATE FILE NUMBER

FILED MAR 16 1959

Registration District No. 15 Primary Registration District No. 3004 Registrar's No. 18

300
1-57

1. PLACE OF DEATH a. COUNTY <u>Barton</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Barton</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lamar</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Milford Twn ship</u> c 6 6 0 Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Memorial Hosp.</u>		Length of stay in lb <u>3 days</u>	d. STREET ADDRESS (If outside, give location) <u>North of Milford</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Rebecca</u> Middle <u>Williams</u> Last <u>Williams</u>			4. DATE OF DEATH Month <u>March</u> Day <u>8</u> Year <u>1959</u>		
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5. SEX <u>Female</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>Nov. 18 1877</u>	9. AGE (In years last birthday) <u>81</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (City and state or country) <u>Barton Co. Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>US</u>
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13a. FATHER'S NAME <u>William Sullens</u>	13b. MOTHER'S MAIDEN NAME <u>Nancy Denny</u>	14. NAME OF HUSBAND OR WIFE <u>L. Harrison William</u>
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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>Emery Williams</u>	Address <u>Lamar, Mo. R R</u>
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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) <u>Coronary occlusion</u> <u>Pneumonia, Rt Lung</u> DUE TO (b) <u>3 days</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. 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>Bronchitis, old</u>		INTERVAL BETWEEN ONSET AND DEATH <u>a few minutes</u> <u>3 days</u>
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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 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 _____
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21. I attended the deceased from <u>Aug 23, 55</u> to <u>March 8, 59</u> and last saw her alive on <u>March 8, 1959</u> Death occurred at <u>607 Pika</u> m on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <u>Ben T. Biebel, MD</u> (Degree or title)	22b. ADDRESS <u>Lamar, Mo.</u>	22c. DATE SIGNED <u>3/9/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Mar. 11 59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. James</u>	23d. LOCATION (City, town, or county) <u>Barton Co. Mo.</u> (State)
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24. FUNERAL DIRECTOR <u>Emery Funeral Home, Shields Ave</u> ADDRESS _____	25. DATE RECD. BY LOCAL REG. <u>MAR 9 - 59</u>	26. REGISTRAR'S SIGNATURE <u>Marie Komantz</u>
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(Licensed Embolmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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.

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 *L. Gerald Keeney*

Licensed Embalmer No. *4203*
P. O. Address *Sheldon, Me.*

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.