

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-008693
STATE FILE NUMBER

FILED APR 8 1959 Registration District No. 59 Primary Registration District No. Registrar's No. 66

300
1-57 4

1. PLACE OF DEATH a. COUNTY <u>Cass</u>		2. USUAL RESIDENCE (Where deceased lived. If inscription: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rural Peculiar Twp</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Independence</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>Pleasant View Rest Home</u> Length of stay in 1b <u>4yr</u>		d. STREET ADDRESS (If outside, give location) <u>201 W. St Charles</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>LOUIS Casper WILLIAMS</u>			4. DATE OF DEATH Month Day Year <u>April 8 1959</u>		
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr 25-1871</u>	9. AGE (In years last birthday) <u>87</u>	FUNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railroad Laborer</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Cass Co Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Robert Williams</u>	13b. MOTHER'S MAIDEN NAME <u>Etha Linda Smith</u>	14. NAME OF HUSBAND OR WIFE <u>Dise Williams</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>496-09-1597</u>	17. INFORMANT Address <u>Martha J. Winkler, Archimemo</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>Pulmonary edema</u> DUE TO (b) <u>Thromboangiitis obliterans</u> DUE TO (c) <u>arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> <u>6 mo</u> <u>3 yrs</u>
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 Month, Day, Year a.m. p.m.
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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
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21. I attended the deceased from Jan 1957 to Apr 4, 1959 and last saw her/him alive on Apr 4, 1959
Death occurred at 3 am m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>H. E. Groesch M.D.</u>	22b. ADDRESS <u>Harrisonville</u>	22c. DATE SIGNED <u>Apr 7, 1959</u>
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23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Funeral</u>	23b. DATE <u>Apr 6 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Freeman Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Harrisonville Mo</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Remmenburgis Harrisonville Mo</u>	25. DATE RECD. BY LOCAL REG. <u>4-4-1959</u>	26. REGISTRAR'S SIGNATURE <u>Mrs Ray Sabree</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.

APR 16 1959

CLATSOP COUNTY
HEALTH DEPARTMENT

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 Frank E. Rannenberg, Student Embalmer No. 568 working under my personal supervision.

Student Frank E. Rannenberg Signed James R. Phillips
Signature of Student Embalmer

Licensed Embalmer No. 4441

P. O. Address Harrisonville, Mo.

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.