

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-014144

FILED MAY 1 1959 Registration District No. 209 Primary Registration District No. 3043 STATE FILE NUMBER Registrar's No. 1257

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-57

1. PLACE OF DEATH a. COUNTY Marion		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Marion	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Hannibal		c. CITY OR TOWN Hannibal 06440	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Elizabeth Hospital		d. STREET ADDRESS (If outside, give location) 616 North	

3. NAME OF DECEASED (Type or print) First Middle Last MARGARET HELEN LEARY WILLIAMS			4. DATE OF DEATH Month Day Year April 25, 1959		
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 29, 1898	9. AGE (In years last birthday) 60	IF UNDER 1 YEAR Months Days 9 26	IF UNDER 24 HRS Hours Min. 0 0
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	10b. KIND OF BUSINESS OR INDUSTRY International Shoe	11. BIRTHPLACE (City and state or country) Paris Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Dennis P. Leary	13b. MOTHER'S MAIDEN NAME Anna M. Smith	14. NAME OF HUSBAND OR WIFE Frank M. Williams
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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)	16. SOCIAL SECURITY NO. 490-07-4672	17. INFORMANT Address Frank M. Williams Hannibal Missouri
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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) Acute myocardial infarct		INTERVAL BETWEEN ONSET AND DEATH 6 weeks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Diabetes Melitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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. Month, Day, Year	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 3-12-59 to 4-25-59 and last saw her/him alive on 4-25-59 Death occurred at 2:05 A. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>Robert Lanning, MD.</i>	22b. ADDRESS 115 N. 5th St. Hannibal, Missouri	22c. DATE SIGNED 4-25-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4/27/1959	23c. NAME OF CEMETERY OR CREMATORY Holy Rosary	23d. LOCATION (City, town, or county) (State) Monroe City Missouri
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24. FUNERAL DIRECTOR ADDRESS W. Crawford Smith Hannibal Missouri	25. DATE RECD. BY LOCAL REG. 4-27-59	26. REGISTRAR'S SIGNATURE <i>Dr. E. M. Lucke</i>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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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 *A. Crawford Smith*

Licensed Embalmer No. 3814
P. O. Address Hannibal Missouri

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.