

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-014173

STATE FILE NUMBER

FILED APR 29 1959

Registration District No.

217

Primary Registration District No.

5787

Registrar's No.

35

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|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Mississippi | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Miss. | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) Charleston | | c. CITY OR TOWN Charleston | |
| c. FULL NAME OF (If NOT in hospital, give location) Route 2 | | d. STREET ADDRESS (If outside, give location) Route 2 | |

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|--|---------------------------------|---|---|--|--|
| 3. NAME OF DECEASED (Type or print) Louise Williams | | | 4. DATE OF DEATH Month April Day 17 Year 1959 | | |
| 5. SEX Female | 6. COLOR OR RACE Col. | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 1, 1893 | 9. AGE (In years last birthday) 65 | IF UNDER 1 YEAR Months 0 Days 0 |

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|---|--|-----------------------------------|--|---|--|---|--|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) New Madrid, Missouri | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13a. FATHER'S NAME Albert Young | | | 13b. MOTHER'S MAIDEN NAME Emeline Watson | | | 14. NAME OF HUSBAND OR WIFE Columbus 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) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address Columbus Williams, Route 2, Charleston, Mo. | | | |
|--|--|-------------------------|--|---|--|--|--|

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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) Cerebral Vascular Accident | | | INTERVAL BETWEEN ONSET AND DEATH 7 days | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Hypertension | | | ? | | |
| DUE TO (c) Atherosclerosis | | | 2 | | |

| | | | | | | |
|---|--|--|---|--|--|--|
| 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.) 331x | | | |
| 20c. TIME OF INJURY Hour 3:30 Month April Day 17 Year 1959 | | | | | | |

| | | | | | | | | | |
|---|--|--|--|--|--|---------------------------|--|-------|--|
| 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 Charleston Mo | | COUNTY Missouri | | STATE | |
|---|--|--|--|--|--|---------------------------|--|-------|--|

21. I attended the deceased from **4-5-59** to **4-10-59** and last saw her/him alive on **4-10-59**
Death occurred at **6:00 P.** m on the date stated above; and to the best of my knowledge, from the causes stated.

| | | | | | | | |
|--------------------------------------|--|-------------------|--|--------------------------------------|--|------------------------------------|--|
| 22a. SIGNATURE <i>W. E. Demme</i> | | (Degree or title) | | 22b. ADDRESS Charleston Mo | | 22c. DATE SIGNED 4/18/59 | |
|--------------------------------------|--|-------------------|--|--------------------------------------|--|------------------------------------|--|

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|---|--|------------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE April 19, 1959 | | 23c. NAME OF CEMETERY OR CREMATORY Fannie Powell Cemetery | | 23d. LOCATION (City, town, or county) (State) New Madrid, Missouri | |
|---|--|------------------------------------|--|---|--|--|--|

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|---|--|-----------------------------------|--|--|--|--|--|
| 24. GENERAL DIRECTOR <i>L. F. Sparks</i> | | ADDRESS Charleston, Mo. | | 25. DATE RECD. BY LOCAL REG. 4-24-59 | | 26. REGISTRAR'S SIGNATURE <i>Society B. Hathorn</i> | |
|---|--|-----------------------------------|--|--|--|--|--|

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

3953 07 237

MAY 22 1959

FEB 28 1959

MAY 22 1959

Date Filed

APR 30 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 *Edward N. Purpin*

Licensed Embalmer No. 5022
P. O. Address Charleston, 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.