

**R DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

FILED VS AUG 10 1959 **38**

**59-024154**

Registration District No. \_\_\_\_\_ Primary Registration District No. **3006** Registrar's No. **344**

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Boone</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Callaway</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Columbia</b>		Length of stay in 1b <b>14</b>		c. CITY OR TOWN <b>Williamsburg</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Boone Co. Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>R. F. D. 1</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Stella</b> Middle <b>B.</b> Last <b>Williams</b>				4. DATE OF DEATH Month <b>July</b> Day <b>14</b> Year <b>1959</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>11-3-04</b>	9. AGE (last birthday) <b>54</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (City and state or country) <b>Ablene Kansas</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Marion Loveall</b>			13b. MOTHER'S MAIDEN NAME <b>Susie Blair</b>			14. NAME OF HUSBAND OR WIFE <b>Walter Williams</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>DK</b>		17. INFORMANT Address <b>Walter Williams-Williamsburg, Mo.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema</b>							INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <b>congestive heart failure</b>						
		DUE TO (c) <b>arteriosclerotic heart disease</b>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>myocardial infarct may 1959</b>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
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 _____ a.m. _____ p.m.		Month, Day, Year _____						
20d. INJURY OCCURRED <input checked="" type="checkbox"/> 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
21. I attended the deceased from <b>13 may 59</b> to <b>death</b> and last saw her <sup>her</sup> <del>time</del> live on <b>13 Jun 59</b> Death occurred at <b>10:40 a.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <b>Elmer P. Rodgers, M.D.</b>				22b. ADDRESS <b>202 South Tenth</b>			22c. DATE SIGNED <b>14 Jun 59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>7-17-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Ridge</b>		23d. LOCATION (City, town, or county) (State) <b>Holts Summit, Mo.</b>			
24. FUNERAL DIRECTOR <b>Wallace Funeral Home Feulton, Mo.</b>			ADDRESS <b>Aug 5, 1959</b>		25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE <b>Mrs RE Palman</b>	

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

099 31 197

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Denzil C. Browning

Licensed Embalmer No. 2724

P. O. Address Fullon, Va

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.