

PRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-030112

FILED VS SEP 9 1959

Registration District No. 4448 Primary Registration District No. 4424 Registrar's No. 113

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Ray County</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lawsou</u> Length of stay in 1b <u>5 years</u> c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Lawsou</u> Include Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Ray</u> c. CITY OR TOWN <u>Lawsou</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>Lawsou</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY FRANCES WILLIAMS</u>			4. DATE OF DEATH Month Day Year <u>Aug. 28 '59</u>		
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>Mar 21 1877</u>	9. AGE (last birthday) IF UNDER 1 YEAR IF UNDER 24 HR <u>82</u> Months Days Hours Min.	
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>Spickard Mo</u>		11. BIRTHPLACE (City and state or country) <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Joseph McKinnon</u>		13b. MOTHER'S MAIDEN NAME <u>Nancy Bosley</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>	
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 Address <u>Mrs. Mildred Slawens-Peterson Pa</u>	
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>Cerebral degeneration</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>6 mo.</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Parkinson's Disease</u>					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input 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 Month, Day, Year a.m. p.m.		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
21. I attended the deceased from <u>Aug 1 '59</u> to <u>28 Aug 59</u> and last saw her him alive on <u>27 Aug 59</u> Death occurred at <u>12:12 Pm</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>George E Sanders M.D.</u>			22b. ADDRESS <u>Excelsior Springs, Mo.</u>		22c. DATE SIGNED <u>8-28-59</u>
23a. BURIAL, CREATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Aug. 30, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Masonic Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Spickard Mo</u>
24. FUNERAL DIRECTOR ADDRESS <u>Jarman Funeral Home Lawsou Mo</u>			25. DATE REC'D BY LOCAL REG. <u>9-3-1959</u>		26. REGISTRAR'S SIGNATURE <u>Mabel Jackson</u>

DED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Lundeep Jassman

Licensed Embalmer No. 4589
P. O. Address Excelsior Springs, 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.