

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-001348

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Registration District No. 144 Primary Registration District No. 4234 Registrar's No. 9

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>IRON</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>IRON</u>					
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>IRONTON</u>		Length of stay in 1b		c. CITY OR TOWN <u>ANNAPOLIS</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST MARYS HOSPT.</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (if outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>PEARL</u> Middle <u>WILLIAMS</u> Last <u>WILLIAMS</u>				4. DATE OF DEATH Month <u>JAN.</u> Day <u>22</u> Year <u>1960</u>					
5. SEX <u>FEMALE</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>MAY 23, 1894</u>		9. AGE (last birthday) <u>65</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (City and state or country) <u>ANNAPOLIS, MO.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		IF UNDER 1 YEAR Months Days Hours Min.	
13a. FATHER'S NAME <u>JAMES SMITH</u>			13b. MOTHER'S MAIDEN NAME <u>RACHAEL CARNAHAN</u>			14. NAME OF HUSBAND OR WIFE <u>LEE COURTLAND WILLIAMS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>✓</u>			16. SOCIAL SECURITY NO. <u>✓</u>		17. INFORMANT <u>RAY WILLIAMS</u>			Address <u>PIEDMONT, MO</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>Cardiac decompensation</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Atherosclerosis, general</u>							<u>5 years</u>		
DUE TO (c) <u>Myocardial disease, chronic.</u>							<u>10 years</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						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 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 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>June 12, 1959</u> to <u>Jan. 22, 1960</u> and last saw her/him alive on <u>Jan. 21, 1960</u> Death occurred at <u>3:45 am.</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>Ben Mc. Bull, M.D.</u> (Degree or title)				22b. ADDRESS <u>Ironton, Mo.</u>			22c. DATE SIGNED <u>1-26-60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>1-24-1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MEADOWS CEM.</u>		23d. LOCATION (City, town, or county) (State) <u>6 Mi South East ANNAPOLIS, MO</u>			
24. FUNERAL DIRECTOR <u>GISH FUNERAL HOME</u> ADDRESS <u>PIEDMONT MO.</u>				25. DATE RECD. BY LOCAL REG. <u>1-26-60</u>		26. REGISTRAR'S SIGNATURE <u>Ma (Mrs) Jones</u>			

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 me \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

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

Signed Martin E. Brewster

Licensed Embalmer No. 442

P. O. Address Adrian

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.