

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-009500

FILED VS MAR 1 1960 333

Primary Registration District No. 3074 Registrar's No. 62

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Scott</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO.</b> b. COUNTY <b>SCOTT</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Sikeston</b>		Length of stay in 1b <b>12 YRS.</b>		c. CITY OR TOWN <b>SIKESTON</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Mo. Delta Comm. Hospital</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>349 PETTY ST.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>EDWARD</b> Middle <b>WILLIAMS</b> Last <b>WILLIAMS</b>				4. DATE OF DEATH Month <b>2</b> Day <b>21</b> Year <b>1960</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</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>3-4-1900</b>		
9. AGE (last birthday) <b>59</b>		IF UNDER 1 YEAR Months <b>11</b> Days <b>12</b>		IF UNDER 24 HR Hours <b></b> Min. <b></b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMING</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (City and state or country) <b>PRINCESS, MISS.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>LJ WILLIAMS</b>			13b. MOTHER'S MAIDEN NAME <b>-</b>			14. NAME OF HUSBAND OR WIFE <b>IRENE 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>493-26-9983</b>		17. INFORMANT Address <b>IRENE WILLIAMS, SIKESTON, 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>HYPERTENSIVE ENCEPHALOPATHY</b> <b>Ess. HYPERTENSION</b> DUE TO (b) <b>12 hrs</b> DUE TO (c) <b>INTERVAL BETWEEN ONSET AND DEATH</b>								
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 <b></b> a.m. <b></b> p.m. <b></b>		Month, Day, Year <b></b>						
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.) <b>2. 21. 60</b>		20f. CITY, TOWN, OR LOCATION <b>2. 21. 60</b>		COUNTY <b></b> STATE <b></b>		
21. I attended the deceased from <b>8:05 P.</b> to <b>2. 21. 60</b> and last saw him alive on <b>2. 21. 60</b> . Death, occurred at <b>8:05 P.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <b>Carl G. Topop M.D.</b> (Degree or title)				22b. ADDRESS <b>Sikeston, Mo.</b>			22c. DATE SIGNED <b>2.25.60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>2-28-1960</b>		23b. DATE <b>2-28-1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SUNSET</b>		23d. LOCATION (City, town, or county) (State) <b>SIKESTON MO.</b>		
24. FUNERAL DIRECTOR ADDRESS <b>ALVIN DOTSON, SIKESTON, MO.</b>				25. DATE RECD. BY LOCAL REG. <b>3-3-60</b>		26. REGISTRAR'S SIGNATURE <b>Miss Edna Hunter</b>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

MAR 11 1961

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 Erin S. Marshave

Licensed Embalmer No. 4601  
P. O. Address Superston

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.