

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-022420

STATE FILE NUMBER

FILED VS. **PL 11 1960**

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Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Buchanan</b> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b> Length of stay in 1b <b>20 Yrs</b> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Missouri Methodist Hosp.</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b> c. CITY OR TOWN <b>St. Joseph</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <b>Ashland Lane</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Merrill</b> Middle <b>Bower</b> Last <b>Williams</b>			<b>4. DATE OF DEATH</b> Month <b>July</b> Day <b>4</b> Year <b>1960</b>				
<b>5. SEX</b> Male	<b>6. COLOR OR RACE</b> White	<b>7. Married</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> July 26, 1899	<b>9. AGE (last birthday)</b> 60	<b>IF UNDER 1 YEAR</b> Months _____ Days _____ Hours _____ Min. _____		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) Freight Agent		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> C. B. O. Rail Road		<b>11. BIRTHPLACE</b> (City and state or country) Shenandoah, Iowa	<b>12. CITIZEN OF WHAT COUNTRY</b> USA		
<b>13a. FATHER'S NAME</b> Alonzo Williams		<b>13b. MOTHER'S MAIDEN NAME</b> Lulu Cora Power		<b>14. NAME OF HUSBAND OR WIFE</b> (wife) Betty Williams			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) No		<b>16. SOCIAL SECURITY NO.</b> None		<b>17. INFORMANT</b> (wife) Betty Williams St. Joseph, Mo. Address _____			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion with 1 Hour</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>A-V Bundle Branch Block</b> DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <input type="checkbox"/> Yes <input type="checkbox"/> N. <input type="checkbox"/> Unknown		
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"/> N. <input type="checkbox"/> Unknown		
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.) _____					
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	<b>20f. CITY, TOWN, OR LOCATION</b> _____ <b>COUNTY</b> _____ <b>STATE</b> _____		
<b>21. I attended the deceased from</b> <u>10</u> to <u>10:30 PM</u> and last saw him alive on <u>7.4.60</u> Death occurred at <u>10:30 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> (Degree or title) <i>[Signature]</i>			<b>22b. ADDRESS</b> St Joseph Mo		<b>22c. DATE SIGNED</b> 7.4.60		
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) Burial	<b>23b. DATE</b> July 7, 1960	<b>23c. NAME OF CEMETERY OR CREMATORY</b> Memorial Park Cemetery		<b>23d. LOCATION</b> (City, town, or county) (State) St. Joseph, Missouri			
<b>24. FUNERAL DIRECTOR</b> ADDRESS <i>[Signature]</i>			<b>25. DATE RECD. BY LOCAL REG.</b> July 8, 1960	<b>26. REGISTRAR'S SIGNATURE</b> <i>[Signature]</i>			

DOCUMENT

P.A. Knapp, M.D. MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JUL 25 1980

**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 Bill J. Channing

Licensed Embalmer No. 4679

P. O. Address St. Joseph

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.