ISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-010167
STATE FILE NUMBER

AMENDED

Registration District No. 290 Primary Registration District No. 4427 Registrar's No. 29

FILED MAR 30 1961

1. PLACE OF DEATH
a. COUNTY Pulaski
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Waynesville — Length of stay in 1b: 3 Weeks
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION General Hospital — Inside Limits Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Pulaski
c. CITY OR TOWN Crocker — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) -- — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First Charley — Middle - — Last Williams
4. DATE OF DEATH: Month March — Day 10 — Year 1961
5. SEX: Male
6. COLOR OR RACE: White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: April 8 1874
9. AGE (last birthday): 86 — IF UNDER 1 YEAR: Months 11, Days 6 — IF UNDER 24 HR: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Blacksmith
10b. KIND OF BUSINESS OR INDUSTRY: Commercial
11. BIRTHPLACE (City and state or country): Pulaski County
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: Elias Williams
13b. MOTHER'S MAIDEN NAME: Missouri Cox
14. NAME OF HUSBAND OR WIFE: Zora Williams
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): -------
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Dewey Williams — Address: Crocker Missouri

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchial Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 wks.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Myocardial Failure — 10 days.
DUE TO (c) Senility
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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 Feb. 20. 1961 to March 10, 1961 and last saw her/him alive on March 10, 1961
Death occurred at 3:30 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: John A. Mikalevich (Degree or title) DO
22b. ADDRESS: Crocker, Missouri
22c. DATE SIGNED: 3/15/61

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 3/16/61
23c. NAME OF CEMETERY OR CREMATORY: Crocker Memorial Cem.
23d. LOCATION (City, town, or county) (State): Crocker Missouri

24. FUNERAL DIRECTOR: Moss-Williams Funeral Homes — ADDRESS: Crocker Mo
25. DATE RECD. BY LOCAL REG.: 3-15-61
26. REGISTRAR'S SIGNATURE: Euba Inez Anderson

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED — INSTEAD OF — SHOULD READ — ITEM NO. — DOCUMENT — 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 me,

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed Clarence Thomas

Signature of Student Embalmer

Licensed Embalmer No. 4896

P. O. Address Waynesville, 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.