MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-018292
STATE FILE NUMBER

AMENDED

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 183

FILED MAY 29 1961

1. PLACE OF DEATH
a. COUNTY Marion
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Hannibal
Length of stay in 1b: lifetime
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Becky Thatcher Home
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY Marion
c. CITY OR TOWN Hannibal
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 121a Bird St.
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First JOHN Middle MARION Last WILLIAMS
4. DATE OF DEATH: Month May Day 18 Year 1961
5. SEX: male
6. COLOR OR RACE: white
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 10/31/77
9. AGE (last birthday): 83
IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HR: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): deliveryman
10b. KIND OF BUSINESS OR INDUSTRY: beer distributor
11. BIRTHPLACE (City and state or country): Marion Co., Mo.
12. CITIZEN OF WHAT COUNTRY: United States
13a. FATHER'S NAME: Albert R. Williams
13b. MOTHER'S MAIDEN NAME: Sarah A. Peyton
14. NAME OF HUSBAND OR WIFE: ---
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.:
17. INFORMANT: J. W. Northcutt, 501 Country Club Dr. Address: Hannibal, Mo.

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) Coronary occlusion
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Generalized arteriosclerosis
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH
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 ____, to ____ and last saw her/him alive on ____
Death occurred at 10:00 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE T. J. Fischer M.D. (Degree or title)
22b. ADDRESS Hannibal, Mo.
22c. DATE SIGNED 5/23/61

23a. BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE: 5/20/61
23c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery
23d. LOCATION (City, town, or county) (State): Hannibal, Mo.

24. FUNERAL DIRECTOR: Frank Schwartz ADDRESS: Hannibal, Mo.
25. DATE RECD. BY LOCAL REG.: 5/25/61
26. REGISTRAR'S SIGNATURE: Dr. E. M. Luche by Lillian M. Herman

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED | INSTEAD OF | SHOULD READ | ITEM NO.
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
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_____
Signature of Student Embalmer

Signed Jack Schwartz

Licensed Embalmer No. 4900

P. O. Address Honolulu

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.