

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-031536

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 324  
**FILED SEP 11 1961**

Primary Registration District No. 6093

Registrar's No. 166

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <b>Saline</b>	b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Marshall</b>	a. STATE <b>Missouri</b>	b. COUNTY <b>New Madrid</b>
Length of stay in lb OR TOWN <b>1 mo 24 da.</b>		c. CITY OR TOWN <b>Portageville</b>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Marshall State School &amp; Hosp.</b>		d. STREET ADDRESS <b>----</b>	Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First <b>Jimmie</b>	Middle <b>Lee</b>	Last <b>Williams</b>	4. DATE OF DEATH	Month <b>Sept.</b>	Day <b>5,</b>	Year <b>1961</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>12-17-1951</b>	9. AGE (last birthday) <b>9 yrs.</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Patient</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	11. BIRTHPLACE (City and state or country) <b>Portageville, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Thomas Williams</b>	13b. MOTHER'S MAIDEN NAME <b>Luller Davis</b>	14. NAME OF HUSBAND OR WIFE <b>---</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Records of Marshall State School &amp; Hosp., Marshall, Mo.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH <b>25 days</b>
IMMEDIATE CAUSE (a) <b>Branchial Pneumonia</b>	DUE TO (b)	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Epileptic, chronic invalid, mental retardation severe</b>	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
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)
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20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year
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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
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21. I attended the deceased from **4-1-1959** to **9-5-1961** and last saw him alive on **9-5-1961**  
 Death occurred at **1:54 p.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Robert B. Day M.D.</b>	22b. ADDRESS <b>Marshall State School &amp; Hosp., Marshall, Mo.</b>	22c. DATE SIGNED <b>9-5-61</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>9-8-'61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Anatomical Board Case</b>	23d. LOCATION (City, town, or county) (State) <b>Kirkville, Missouri</b>
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24. FUNERAL DIRECTOR <b>George H. Green</b>	ADDRESS <b>Fulton, Missouri</b>	25. DATE RECD. BY LOCAL REG. <b>9-8-'61</b>	26. REGISTRAR'S SIGNATURE <b>Clair G. Read</b>
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DATE AMENDED  
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 SHOULD READ  
 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 George H. Green

Licensed Embalmer No. 4220

P. O. Address Salmon, 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.