

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-040249

STATE FILE NUMBER

AMENDED

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 1202

FILED DEC 4 1961

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Length of stay in lb most of life	c. CITY OR TOWN St. Joseph Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Memorial Home 1120 Main		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1120 Main St. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First MARY Middle ELIZABETH Last WILLIAMS			4. DATE OF DEATH Month November Day 18 Year 1961		
---	--	--	--	--	--

5. SEX female	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12/20/1871	9. AGE (last birthday) 89	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
-------------------------	----------------------------------	---	---------------------------------------	-------------------------------------	---	------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework	10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (City and state or country) Hannibal, Mo.	12. CITIZEN OF WHAT COUNTRY USA
---	--	--	---

13a. FATHER'S NAME Joseph Williams	13b. MOTHER'S MAIDEN NAME Mary Frances Foster	14. NAME OF HUSBAND OR WIFE
--	---	-----------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. none	17. INFORMANT Address Memorial Home Records, St. Joseph, Mo.
---	--	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia		INTERVAL BETWEEN ONSET AND DEATH 14 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Chronic Nephritis & Hypertension	
	DUE TO (c)	

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 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.)
---	---	--

20c. TIME OF INJURY Hour 8:45 a. Month, Day, Year Nov 5, 1961	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
--	--	--	---

21. I attended the deceased from Nov 5, 1961 to Nov 18, 1961 and last saw her alive on Nov 18, 1961 Death occurred at 8:45 a. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) S.E. Senior M.D.	22b. ADDRESS St. Joseph Mo	22c. DATE SIGNED 11-21-61
---	--------------------------------------	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 11/20/1961	23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery	23d. LOCATION (City, town, or county) (State) St. Joseph Missouri
--	--------------------------------	--	---

24. FUNERAL DIRECTOR ADDRESS Heston-Bowman, St. Joseph, Mo.	25. DATE RECD. BY LOCAL REG. Nov 22, 1961	26. REGISTRAR'S SIGNATURE Mrs. Clark Handell
---	---	--

DATE AMENDED

INSTEAD OF

DOCUMENT

S.E. Senior, M.D. MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

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 William Spaulding

Licensed Embalmer No. 4535

P. O. Address Bozrah, 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.