

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-041406

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. *146*

Primary Registration District No. *3026*

Registrar's No. *577*

FILED DEC 12 1961

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Independence</b>		c. CITY OR TOWN <b>Independence</b>	
Length of stay in 1b <b>68 yrs.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>700 W. Charles</b>		d. STREET ADDRESS (If outside, give location) <b>700 W. Charles</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <b>MRS. LINNIE CECILIA WILLIAMS</b>			4. DATE OF DEATH <b>November 30, 1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 1, 1891</b>	9. AGE (last birthday) <b>69</b>
IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Months Days Hours Min.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Turner, Kansas</b>
12. CITIZEN OF WHAT COUNTRY <b>USA</b>	13a. FATHER'S NAME <b>William Blatt</b>	13b. MOTHER'S MAIDEN NAME <b>Margaret Clemenson</b>	14. NAME OF HUSBAND OR WIFE <b>George Williams</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>			17. INFORMANT Address <b>Mr. George Williams 700 W. Charles, Indep., Mo.</b>	

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
IMMEDIATE CAUSE (a) <b>Myocardial Infarction acute</b>		<b>Immediate</b>
DUE TO (b) <b>Arteriosclerotic Heart Disease</b>		
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 a.m. p.m.	Month, Day, Year	

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 **1952** to **Present** and last saw her **alive** on **11/28/61**  
Death occurred at **2:45 p.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Ink) <i>E. B. Walton MD</i>	22b. ADDRESS <b>10901 Winner Rd Independence Mo</b>	22c. DATE SIGNED <b>12/1/61</b>
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Dec. 2, 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Marys Cemetery</b>
23d. LOCATION (City, town, or county) <b>Independence, Missouri</b>		

24. FUNERAL DIRECTOR ADDRESS <b>OTT &amp; MITCHELL, Indep., Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>12-2-61</b>	26. REGISTRAR'S SIGNATURE <i>Alba L. Craig</i>
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DATE AMENDED

INSTEAD OF

BY AFFIDAVIT OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS DEC 13 1931

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 *[Handwritten Signature]*

Licensed Embalmer No. 3156

P. O. Address *[Handwritten Address]*

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.