

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-004781

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 324 Primary Registration District No. 3072 Registrar's No. 22

FILED FEB 4 1963

1. PLACE OF DEATH a. COUNTY <u>Saline</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Saline</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Marshall, Mo.</u>		Length of stay in 1b	c. CITY OR TOWN <u>Malta Bend</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Fitzgibbons Hosp.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>Marlin</u> Last <u>Williams</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>1</u> Year <u>1963</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6-19-1883</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Long Lane, Mo.</u>	9. AGE (last birthday) <u>79</u>
13a. FATHER'S NAME <u>John W. Williams</u>		13b. MOTHER'S MAIDEN NAME <u>Martha Clayton</u>	11. BIRTHPLACE (City and state or country) <u>USA</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes; no; No known) (If yes, give war or dates) <u>No</u>		17. INFORMANT <u>Martha Jackson</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		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	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 _____	
21. I attended the deceased from <u>1-17-63</u> to <u>2-2-63</u> and last saw her alive on <u>2-1-63</u> Death occurred at <u>7:45 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>James A. Reid MD</u>		22b. ADDRESS <u>Marshall Mo</u>	
22c. DATE SIGNED <u>2-2-63</u>		23. LOCATION (City, town, or county) (State) <u>Malta Bend Missouri</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Feb 3, 1963</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Malta Bend Cemetery</u>		23d. DATE RECD. BY LOCAL REG. <u>Feb 3 - 63</u>	
24. FUNERAL DIRECTOR <u>Jack W. Reser</u>		26. REGISTRAR'S SIGNATURE <u>Carl S. Reed</u>	

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DATE AMENDED
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF
ITEM NO. SHOULD READ
BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

FEB 7 1963

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

Bill McLaughlin

Licensed Embalmer No. 5760

P. O. Address Marshall, 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.