

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=63-016716

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 304 Primary Registration District No. 3089 Registrar's No. 278

DO NOT WRITE ON THIS STUB

AMENDED

FILED MAY 7 1963	
1. PLACE OF DEATH a. COUNTY <u>Lincoln</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>MARCELINE</u> Length of stay in 1b <u>6 Mo</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST FRANCIS Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>CHARITON</u> c. CITY OR TOWN <u>SUMNER MO</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>SALLIE</u> Middle <u>WILLIAMS</u> Last 5. SEX <u>FEMALE</u> 6. COLOR OR RACE <u>White</u> 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> 8. DATE OF BIRTH <u>April 9-1898</u> 9. AGE (last birthday) <u>85</u> IF UNDER 1 YEAR Months <u>0</u> Days <u>19</u> IF UNDER 24 HR Hours <u></u> Min. <u></u>	4. DATE OF DEATH Month <u>April</u> Day <u>28</u> Year <u>1963</u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u> 11. BIRTHPLACE (City and state or country) <u>SUMNER MO</u> 12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>William McKee</u> 13b. MOTHER'S MAIDEN NAME <u>MARtha Fields</u> 14. NAME OF HUSBAND OR WIFE <u>OTHA Williams</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) <u>no</u> 16. SOCIAL SECURITY NO. <u></u> 17. INFORMANT <u>MAURICE Williams MARCELINE MO</u> Address <u></u>	18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Pneumonitis</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> DUE TO (b) <u>Severe Acute Cardiac Decompensation & pulmonary edema.</u> <u>4 days</u> DUE TO (c) <u>ASAD + Atrial Fibrillation</u> <u>Indefinite</u> 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 SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 . Month, Day, Year a.m. p.m.	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>1960</u> to <u>1963</u> and last saw him alive on <u>4/28/63</u> Death occurred at <u>9:30</u> A.M. on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <u>Glenn A. Horner, MD</u>	22b. ADDRESS <u>Marceline, MO.</u> 22c. DATE SIGNED <u>4/28-63</u> (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE <u>4-30-63</u> 23c. NAME OF CEMETERY OR CREMATORY <u>LAKESIDE</u> 23d. LOCATION (City, town, or county) <u>SUMNER MO</u>	24. FUNERAL DIRECTOR ADDRESS <u>S.L. LEIPARD MEMPHIS MO</u> 25. DATE RECD. BY LOCAL REG. <u>4-29-63</u> 26. REGISTRAR'S SIGNATURE <u>Anna Watson</u>

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DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

MAY 8 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 *A. L. Lipard*

Licensed Embalmer No. 3970

P. O. Address WENDELL 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.