

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-027671

STATE FILE NUMBER

Registration District No. 75 Primary Registration District No. 5291 Registrar's No. 76

DO NOT WRITE ON THIS STUB

AMENDED

FILED JUL 16 1963

1. PLACE OF DEATH a. COUNTY <u>Clay</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clay</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Liberty Twp.</u>		Length of stay in lb <u>5 months</u>	c. CITY OR TOWN <u>Excelsior Springs</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Clay County Home</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Waller Street</u>
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First <u>Albert</u> Middle <u>Williams</u> Last <u>Williams</u>		Month <u>July</u> Day <u>9</u> Year <u>1963</u>	

5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>12-16-1876</u>		9. AGE (last birthday) <u>86</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR	
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>None</u>		11. BIRTHPLACE (City and state or country) <u>Excelsior Springs, Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>					
13a. FATHER'S NAME <u>Jermiah Williams</u>				13b. MOTHER'S MAIDEN NAME <u>Sarah Uane Weathington</u>				14. NAME OF HUSBAND OR WIFE <u>None</u>					

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Goldie Williams, 337 E. Excelsior</u>		Address <u>Excelsior Springs</u>	
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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	
IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u>		<u>2 day</u>	
DUE TO (b) <u>Arteriosclerosis</u>		<u>5 yr</u>	
DUE TO (c)			

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Peptic ulcer</u>		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.)	
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 checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION <u>Liberty, Mo</u>		COUNTY <u>Clay</u>		STATE <u>Missouri</u>	
21. I attended the deceased from <u>1 Dec 62</u> to <u>9 July 63</u> and last saw ^{her} him alive on <u>7 July 63</u> Death occurred at <u>1:30 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.									

22a. SIGNATURE <u>J M Watman, MD</u> (Degree or title)				22b. ADDRESS <u>Liberty, Mo</u>				22c. DATE SIGNED <u>11 July 63</u> (State)	
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>7-9-63</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Crown Hill</u>		23d. LOCATION (City, town, or county) <u>Excelsior Springs, Mo.</u>			
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24. FUNERAL DIRECTOR <u>Prichard Funeral Home, Inc.</u> <u>Excelsior Springs, Missouri</u> ADDRESS			25. DATE RECD. BY LOCAL REG. <u>7-12-63</u>		26. REGISTRAR'S SIGNATURE <u>Mabel Graham</u>				
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DATE AMENDED 2

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

SEP 25 1968

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

Samuel Jarman

Licensed Embalmer No. 4589

P. O. Address Enclison Springs, 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.