

No. 13-40  
17-39  
X23159

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

24666

Registration District No. 85 Primary Registration District No. 1001 State File No. \_\_\_\_\_ Registrar's No. 791

1. PLACE OF DEATH  
(a) County BUCHANAN 3  
(b) City or town ST. JOSEPH  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: ST/TE HOSPITAL No. 2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 54 years  
In this community 54 yrs.  
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Buchanan  
(c) City or town St. Joseph  
(If outside city or town limits, write "RURAL")  
(d) Street No. State Hosp No # 2  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULLNAME Lucy Williams 452  
(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. none

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 7 day 22  
year 1940 hour 5:00 minute 30 P.M.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive X years  
7. Birth date of deceased \_\_\_\_\_ (Month) ? (Day) ? (Year) 1850 ?

21. I hereby certify that I attended the deceased from July 1, 1940 to July 22, 1940  
that I last saw her alive on July 22, 1940  
and that death occurred on the date and hour stated above.

8. AGE: Years about 90 Months ? Days ? If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death arteriosclerotic heart disease  
Duration \_\_\_\_\_

9. Birthplace \_\_\_\_\_ (City, town, or county) Kentucky (State or foreign country)  
10. Usual occupation none  
11. Industry or business \_\_\_\_\_  
12. Name Jos Williams  
13. Birthplace Ky. (City, town, or county) (State or foreign country)  
14. Maiden name Mary Elliott  
15. Birthplace Ky. (City, town, or county) (State or foreign country)

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_ (Includes pregnancy within 3 months of death)

MOTHER FATHER  
16. (a) Informant Relatives Margarette H...  
(b) Address Liberty mo.  
17. (a) Mammy (Burial, cremation, or removal) (b) Date thereof July 23-1940 (Month) (Day) (Year)  
(c) Place: burial or cremation Keassey, Mo  
18. (a) Signature of funeral director Harold Cader  
(b) Address Liberty mo.  
19. (a) 7/22/40 (Date received local registrar) (b) A J Nestle (Registrar's signature)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy no.  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
85 While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury 1  
23. Signature P. S. Tate (M. D. or other) MD  
Address State Hosp # 2 - St Joseph Date signed 7-22-40

WRITE PLAINLY—USE UNFADING, BLACK INK—MAKE A PERMANENT RECORD

**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.....

*Not embalmed*

....., Registered Apprentice No. ....

working under my personal supervision.

Signed *Mam Hessel*

Licensed Embalmer No. *2509*

P. O. Address *Liberty 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 this body is not embalmed, fact should be so stated above.**