

No. 300  
10-48

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 174

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 38 PRIMARY REG. DIST. NO. 3006 Registrar's No. 35

1. PLACE OF DEATH a. COUNTY Boone		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Boone	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Columbia		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Columbia	
c. LENGTH OF STAY (in this place) 2 Weeks		d. STREET ADDRESS (If rural, give location) 109 W. Broadway	
d. FULL NAME OF HOSPITAL OR INSTITUTION Boone County Hospital			

3. NAME OF DECEASED (Type or Print)	a. (First) SUSIE	b. (Middle) A.	c. (Last) WILLIAMS	4. DATE OF DEATH (Month) (Day) (Year) Jan. 27, 1949
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Dec. 15, 1896	9. AGE (In years last birthday) 52	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 1 MIN. Hours	IF UNDER 1 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Boone County, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME Berry W. Vandiver	13b. MOTHER'S MAIDEN NAME Emma Jane Lewis	14. NAME OF HUSBAND OR WIFE J. Ben Williams
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Mrs. Maxwell Berry, Columbia, Mo.	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 1 wk 2 wks 1 wk
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertensive heart disease		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Anemia		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION None	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

21a. ACCIDENT SUICIDE HOMICIDE (Specify) None	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) None	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) None	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? None
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22. I hereby certify that I attended the deceased from 1-14, 1949, to 1-27, 1949, that I last saw the deceased alive on 1-26, 1949, and that death occurred at 4 A. M., from the causes and on the date stated above.

23a. SIGNATURE R. P. Johnson M.D.	(Degree or title)	23b. ADDRESS 16. P. 10th St.	23c. DATE SIGNED 1-27-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Jan. 29, 1949	24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	24d. LOCATION (City, town, or county) (State) Columbia, Mo.
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DATE REC'D BY LOCAL REG. Jan 27 1949	REGISTRAR'S SIGNATURE Mrs R E Palmer	31	25. FUNERAL DIRECTOR'S SIGNATURE PARKER FUNERAL SERVICE, Columbia, Mo.	ADDRESS
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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RECEIVED  
District Health Officer No. 9,  
District File Number  
Date Filed JAN 31 1949

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.

Signed \_\_\_\_\_  
Student, Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. 3893

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