

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED APR 29 1949

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 363

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

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1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, write RURAL and give township) Springfield		c. CITY (If outside corporate limits, write RURAL and give township) Bois Darc - Rural	
d. FULL NAME OF HOSPITAL OR INSTITUTION Burge Hospital		d. STREET ADDRESS (If rural, give location) R. # 1	
3. NAME OF DECEASED (Type or Print) a. (First) William b. (Middle) Robert c. (Last) Williams		4. DATE OF DEATH (Month) (Day) (Year) April 22, 1949	
5. SEX M	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH July 2, 1885
9. AGE (In years last birthday) 64		10. UNDER 1 YEAR 3	11. UNDER 24 HRS. 20
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Oklahoma		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME George Williams		13b. MOTHER'S MAIDEN NAME Sarah Wells	
14. NAME OF HUSBAND OR WIFE Zella Williams		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. -		17. INFORMANT'S SIGNATURE OR NAME Lela Gimmett	
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arterial hypertension ANTECEDENT CAUSES unknown DUE TO (b) unknown DUE TO (c) unknown II. OTHER SIGNIFICANT CONDITIONS Uremia 449X	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH sev. yrs.	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR ✓	
22. I hereby certify that I attended the deceased from 4-21, 1949 , to 4-22, 1949 , that I last saw the deceased alive on 4-22, 1949 , and that death occurred at 1:30 P.M. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) W. W. Hansford, M.D.		23b. ADDRESS Springfield, Mo.	23c. DATE SIGNED 4-22-49
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 4-24-49	24c. NAME OF CEMETERY OR CREMATORY Garoute	24d. LOCATION (City, town, or county) (State) Greene Mo.
DATE RECD BY LOCAL REG. 4/28/49	REGISTRAR'S SIGNATURE W. E. Handley, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Morris-Liman Funeral Home	

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
Student Embalmer

Signed.....

E. R. Lemmon

Licensed Embalmer No. *3297*

P. O. Address *Miller 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.