

FILED DEC 5 1949

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **39937**

BIRTH NO. _____ REG. DIST. NO. **347** PRIMARY REG. DIST. NO. **4508** Registrar's No. **42**

1. PLACE OF DEATH a. COUNTY Stone		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Stone	
b. CITY (If outside corporate limits, write RURAL and give township) Galena	c. LENGTH OF STAY (In this place) 1	c. CITY (If outside corporate limits, write RURAL and give township) Galena	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location) 0	

3. NAME OF DECEASED (Type or Print) a. (First) Fred b. (Middle) James c. (Last) Williams			4. DATE OF DEATH (Month) (Day) (Year) Nov 10 1949		
5. SEX m	6. COLOR OR RACE wh	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH July 14 1878	9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 12 HRS. Hours Min. 69	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telephone Operator	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Stone Co. Mo	12. CITIZEN OF WHAT COUNTRY? U. S.
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13a. FATHER'S NAME Henry Williams	13b. MOTHER'S MAIDEN NAME Martha Bentley	14. NAME OF HUSBAND OR WIFE Laurel 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. L	17. INFORMANT'S SIGNATURE OR NAME Mr. Paul Williams	ADDRESS Galena Mo
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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 hr.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral stroke		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		151X	

19a. DATE OF OPERATION Nov 15 1949	19b. MAJOR FINDINGS OF OPERATION Stroke Brain Anoxemia	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) m.	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 **April**, 19**49**, to **Nov**, 19**49**, that I last saw the deceased alive on **1 Nov**, 19**49**, and that death occurred at **8 a** m., from the causes and on the date stated above.

23a. SIGNATURE J. J. Murray M.D.	(Degree or title)	23b. ADDRESS Galena Mo	23c. DATE SIGNED 12-14-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Nov 11 - 49	24c. NAME OF CEMETERY OR CREMATORY Galena	24d. LOCATION (City, town, or county) (State) Galena Mo
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DATE REC'D BY LOCAL REG. Nov. 12 - 49	REGISTRAR'S SIGNATURE Lena Murray	25. FUMERAL DIRECTOR'S SIGNATURE Dep. Everett G. Cheatham	ADDRESS Galena Mo
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

104
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0

RECEIVED NOV 21 1949
District Health Office No. 6,
District File Number 1149-1273
Date Filed 11-30-49

AUG 25 1954

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 Everett J. Cheatham

Licensed Embalmer No. 3870

P. O. Address Halena m

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.