S. No. 300
v. 10.48

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FILED DEC 21 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 40402

BIRTH NO. _____ REG. DIST. NO. 47 PRIMARY REG. DIST. NO. 3008 Registrar's No. 399

1. PLACE OF DEATH
a. COUNTY Callaway
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Fulton 2
c. LENGTH OF STAY (in this place) 7 yr 1 m 2 d
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) State Hosp #1

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Mo
b. COUNTY Saline
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Marshall
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) EARNEST b. (Middle) c. (Last) WILLIAMS

4. DATE OF DEATH (Month) (Day) (Year) Dec 12 1949

5. SEX M 2
6. COLOR OR RACE negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) W 2
8. DATE OF BIRTH July 4-1888
9. AGE (In years last birthday) 61 | IF UNDER 1 YEAR Months 5 Days 8 | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10b. KIND OF BUSINESS OR INDUSTRY dK
11. BIRTHPLACE (State or foreign country) Mo
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME John Williams
13b. MOTHER'S MAIDEN NAME Martha Hutton
14. NAME OF HUSBAND OR WIFE dK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) dK (If yes, give war or dates of service) dK
16. SOCIAL SECURITY NO. dK
17. INFORMANT'S SIGNATURE OR NAME Preston Williams ADDRESS Marshall

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Epilepsy

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.

INTERVAL BETWEEN ONSET AND DEATH

3533

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

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 ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-10, 1949, *to* 12/12, 1949, *that I last saw the deceased alive on* 12-11, 1949, *and that death occurred at* 6a *m., from the causes and on the date stated above.*

23a. SIGNATURE M. J. Miller (Degree or title) MD.
23b. ADDRESS State Hosp #1 Fulton Mo
23c. DATE SIGNED 12-12-49

24a. BURIAL, CREMATION, REMOVAL (Specify)
24b. DATE 12-14-49
24c. NAME OF CEMETERY OR CREMATORY anatomical Board
24d. LOCATION (City, town, or county) Columbia (State) Mo

DATE REC'D BY LOCAL REG. Dec-14-1949
REGISTRAR'S SIGNATURE Maritta Lawrence 426
25. FUNERAL DIRECTOR'S SIGNATURE J. B. Roberts ADDRESS Columbia Mo

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED DEC 19 1949
District Health Officer No. 9,
District File Number.....

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.....

.....,

working under my personal supervision.

Student Embalmer No.....

Signed.....

Signed.....
Student Embalmer

Licensed Embalmer No.....

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.