

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

State File No. **43904**

FILED JAN 4 1952

BIRTH NO. _____ REG. DIST. NO. **372** PRIMARY REG. DIST. NO. **4349** Registrar's No. **12**

1. PLACE OF DEATH a. COUNTY Webster		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY Texas	
b. CITY OR TOWN Seymour Mo.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Licking Mo	
d. FULL NAME OF HOSPITAL OR INSTITUTION M		d. STREET ADDRESS (If rural, give location) -	

3. NAME OF DECEASED (Type or Print) a. (First) Martha b. (Middle) Ellen c. (Last) Williams			4. DATE OF DEATH (Month) (Day) (Year) 12-6-1951		
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Nov 6, 1883	9. AGE (In years last birthday) 68 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Mins.	
10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY <input checked="" type="checkbox"/>	11. BIRTHPLACE (State or foreign country) Texas Mo		12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME Geo W. Lee	13b. MOTHER'S MAIDEN NAME Jane Ellen Parkhurst Williams	14. NAME OF HUSBAND OR WIFE T. J. Williams Licking Mo
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 ADDRESS T. J. Williams Licking Mo

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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2 Days 2 WKS 2 YEARS
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Medullary Failure		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Thrombotic Encephalomalacia DUE TO (c) Arteriosclerosis		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 332X	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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)	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 **Nov-18, 1951**, to **Dec-6, 1951**, that I last saw the deceased alive on **Dec-6, 1951** and that death occurred at **8:00 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) J. R. Gell 2nd	23b. ADDRESS Seymour	23c. DATE SIGNED 12/6/51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 12/9/51	24c. NAME OF CEMETERY OR CREMATORY Licking Cemetery	24d. LOCATION (City, town, or county) (State) Licking Mo
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DATE REC'D BY LOCAL REG. 12-24-51	REGISTRAR'S SIGNATURE Hilbert Jones	3431-0	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Smith Ferguson Licking Mo
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed _____

Gayle V. Elliott

Licensed Embalmer No. 22,572

P. O. Address Cabool

Signed _____
Student Embalmer

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.