

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

RECEIVED
 State File No. 3201 SS MAI
 Registrar's No. 3

407

FILED JAN 25 1952
 BIRTH NO. 83792-51 REG. DIST. NO. 43 PRIMARY REG. DIST. NO. 3807

0124
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Dr Post

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

1. PLACE OF DEATH a. COUNTY Butler			2. USUAL RESIDENCE (Where deceased lived) If institution: residence before admission. a. STATE Missouri b. COUNTY Butler		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Poplar Bluff		c. LENGTH OF STAY (In this place) Life	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Poplar Bluff		0120
d. FULL NAME OF HOSPITAL OR INSTITUTION Poplar Bluff Hospital			d. STREET ADDRESS (If rural, give location) Route 3		
3. NAME OF DECEASED (Type or Print) Jimmie Alfred Williams			4. DATE OF DEATH (Month) (Day) (Year) Jan 15 1952		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Infant	8. DATE OF BIRTH Oct. 15, 1952		9. AGE (In years last birthday) 3
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Poplar Bluff, Mo. 0		12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME Samuel Williams		13b. MOTHER'S MAIDEN NAME Ruby Pettegrew		14. NAME OF HUSBAND OR WIFE	
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 - ADDRESS Samuel Williams Poplar Bluff, 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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia, bilateral, bronchial ANTECEDENT CAUSES Asorbid 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. Marasmus				INTERVAL BETWEEN ONSET AND DEATH 2 days Unknown
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 49ix				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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 checked="" type="checkbox"/> NOT WHILE WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1-15, 1952, to 1-15, 1952, that I last saw the deceased alive on 1-15, 1952, and that death occurred at 9:30 p.m., from the causes and on the date stated above.					
23a. SIGNATURE J.W. Jonda (Degree or title) MD			23b. ADDRESS Poplar Bluff, Mo.		23c. DATE SIGNED 1-16-52
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 1-16-52	24c. NAME OF CEMETERY OR CREMATORY Vahalla		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
DATE REC'D BY LOCAL REG. Jan. 16-1952	REGISTRAR'S SIGNATURE Wm. H. Johnson 428		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Greer Croy & Fitch Poplar Bluff, Mo.		

RECEIVED
JAN 22 1952

BUTLER CO. HEALTH CENTER

FILE No. 152-29

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

Joseph J. Matlock

Licensed Embalmer No. 4034

P. O. Address Palmer, Butler Co., Pa.

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.