

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **4179**

FILED MAR 3 1952

BIRTH NO. _____ REG. DIST. NO. **47** PRIMARY REG. DIST. NO. **3008** Registrar's No. **68**

1. PLACE OF DEATH a. COUNTY Callaway		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Callaway	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Fulton		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Williamsburg, 0140	
c. LENGTH OF STAY (In this place) 7 Days		d. STREET ADDRESS (If rural, give location) R. F. D.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Callaway Co., Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Nina b. (Middle) Lee c. (Last) Williamson			4. DATE OF DEATH (Month) (Day) (Year) Feb. 24 1952		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH June 5, 1893		9. AGE (In years last birthday) 58		IF UNDER 1 YEAR Months 9 Days 19	
IF UNDER 1 YEAR Hours Mins. 		10a. USUAL OCCUPATION (Give kind of work done during most of working life or if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (City and State or Foreign Country) Farber, Missouri			12. CITIZEN OF WHAT COUNTRY? U. S. A.		

13a. FATHER'S NAME Richard Williams		13b. MOTHER'S MAIDEN NAME Minnie C. Frankum		14. NAME OF HUSBAND OR WIFE Russell G. Willimason	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Russell G. Willimason, Williamsburg	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ac. Pulmonary Embolus		DUPLICATE OF (b) fracture of hip			+ 10 minutes	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUPLICATE OF (c) U. S. Pneumonia			+ 2 weeks ago	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					+ a week	

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 014			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) (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 2/20 1952 , to 2/24 1952 , that I last saw the deceased alive on 2/24 1952 , and that death occurred at 11:30 P.M. , from the causes and on the date stated above.						

23a. SIGNATURE (Degree or title) Henry D. ... M.D.		23b. ADDRESS Fulton, Mo.		23c. DATE SIGNED 2/25/52			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Feb. 28, 1952		24c. NAME OF CEMETERY OR CREMATORY Hillcrest		24d. LOCATION (City, town, or county) (State) Fulton Mo	

DATE REC'D BY LOCAL REG. Feb. 25-1952		REGISTRAR'S SIGNATURE Maritta Lawrence		426-0		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wallace Funeral Home, Fulton Mo	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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APR 9 1962

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 William C. Tubee

Licensed Embalmer No. 4870

P. O. Address Fulton, 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.