

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAY 12 1952

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 485

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Harrison</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St Joseph</u>	c. LENGTH OF STAY (In this place) <u>5 day</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>New Hampton</u> <u>0410</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>State Hospital no 2</u>		d. STREET ADDRESS (If rural, give location) <u>Rural</u> <u>1</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Alex</u>	b. (Middle)	c. (Last) <u>Williamson</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>May 3 - 1952</u>
---	-------------	-----------------------------	--

5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed 2</u>	8. DATE OF BIRTH <u>not given</u>	9. AGE (In years last birthday) <u>75</u>	IF UNDER 1 YEAR Months	IF UNDER 4 HRS. Days	IF UNDER 1 HRS. Hours	IF UNDER 15 MIN. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (State or foreign country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>					

13a. FATHER'S NAME <u>John Williamson</u>	13b. MOTHER'S MAIDEN NAME <u>Maria McCune</u>	14. NAME OF HUSBAND OR WIFE <u>not given</u>
--	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mildred S. Richardson</u>	ADDRESS <u>Coopersville Mo</u>
---	--	---	-----------------------------------

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		INTERVAL BETWEEN ONSET AND DEATH <u>Est. 8 mo</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>		
	ANTECEDENT CAUSES DUE TO (b) <u>Arterio sclerosis</u> DUE TO (c) <u>Paralysis of right side</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Arterial occlusion of right leg</u>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>gangrene of right foot & lower leg</u>	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? <u>331X</u>
--	--	---

22. I hereby certify that I attended the deceased from April 25, 1952, to May 3, 1952, that I last saw the deceased alive on May 3, 1952, and that death occurred at 3:45 P.M., from the causes and on the date stated above.

23a. SIGNATURE <u>Forrest Thomas M.D.</u>	(Degree or title)	23b. ADDRESS <u>St Joseph Mo of State Hospital no 2</u>	23c. DATE SIGNED <u>5/3-52</u>
--	-------------------	--	-----------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>5-3-52</u>	24c. NAME OF CEMETERY OR CREMATORY <u>New Hampton, Mo</u>	24d. LOCATION (City, town, or county) (State)
---	----------------------------	--	---

DATE REC'D BY LOCAL REG. <u>May 7, 1952</u>	REGISTRAR'S SIGNATURE <u>Carl C. Cash</u>	411-0	25. FUNERAL DIRECTOR'S SIGNATURE <u>W.C. Noble & Son</u>	ADDRESS <u>New Hampton, Mo.</u>
--	--	-------	---	------------------------------------

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.

Student
Student Embalmer

Signed W.S. Noble

Licensed Embalmer No. 2904

P. O. Address New Hampton, 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.