

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

BIRTH NO. _____ REG. DIST. NO. 306 PRIMARY REG. DIST. NO. 6048

1. PLACE OF DEATH a. COUNTY St. Charles		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Charles	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Peters <i>Bardeine Twp.</i>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Peters <i>Bardeine Twp.</i>	
d. FULL NAME OF HOSPITAL OR INSTITUTION XXXXXXXXXXXXXXXXXXXX		d. STREET ADDRESS (If rural, give location) 0920	

3. NAME OF DECEASED (Type or Print)	a. (First) Landon	b. (Middle) Vince	c. (Last) Williams	4. DATE OF DEATH (Month) (Day) (Year) 4 - 11 - 52
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5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Sept, 3, 1890	9. AGE (In years last birthday) 61	IF UNDER 1 YEAR Months 7 Days 8	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming	10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (State or foreign country) Marthasville, Mo.	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Samuel Williams	13b. MOTHER'S MAIDEN NAME Sophia Mutert	14. NAME OF HUSBAND OR WIFE Mayme Williams
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or date of service) yes Jan. 1919	16. SOCIAL SECURITY NO. 492-01-9394	17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS Mayme Williams, St. Peters, Mo.
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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		INTERVAL BETWEEN ONSET AND DEATH 8
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) with Infarction DUE TO (c) Hypertension with generalized		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Cardiovascular Arteriosclerosis			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 4201	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **4-2**, 19**52**, to **4-11**, 19**52**, that I last saw the deceased alive on **4-9**, 19**52**, and that death occurred at **12:00** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) George R. Sosalik M.D.	23b. ADDRESS Osceola Mo.	23c. DATE SIGNED 4-12-52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 4-14-52	24c. NAME OF CEMETERY OR CREMATORY Wright City	24d. LOCATION (City, town, or county) (State) Wright City, Mo.
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DATE REC'D BY LOCAL REG. 4-14-52	REGISTRAR'S SIGNATURE E. A. Keithly	25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS Geo. Steffner, St. Peters, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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APR 25 1957
APR 25 1957

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

E. Anthony

Licensed Embalmer No. *877*

P. O. Address *Dallas 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.