

STANDARD CERTIFICATE OF DEATH

State File No. **41831**
Registrar's No. **106**

FILED JAN 13 1953

REG. DIST. NO. **75**PRIMARY REG. DIST. NO. **3015**Registrar's No. **106**

1. PLACE OF DEATH a. COUNTY Dekalb Clinton		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before death.) a. STATE Mo, b. COUNTY Clinton	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Cameron		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Cameron	
d. FULL NAME OF HOSPITAL OR INSTITUTION Cameron Hospital		d. STREET ADDRESS (If rural, give location) 0	
3. NAME OF DECEASED a. (First) Assa b. (Middle) Andrew c. (Last) Williamson		4. DATE OF DEATH (Month) (Day) (Year) 12 22 53	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH 3-12-1868
9. AGE (In years last birthday) 84	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	11. BIRTHPLACE (State or foreign country) Mo,	12. CITIZEN OF WHAT COUNTRY? U.S.
13a. FATHER'S NAME Thomas Williamson		13b. MOTHER'S MAIDEN NAME Susan Kilaugh	
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. XXXXXXXX		17. INFORMANT'S SIGNATURE OR NAME Wesley Marshall Osborne ADDRESS 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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebrovascular accident ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) arterio-sclerosis DUE TO (c) senility 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 331X	
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) (Minute) (Second) m.		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 11-24 , 19 53 , to 12-22 , 19 53 , that I last saw the deceased alive on 12-22 , 19 53 , and that death occurred at 8:30 m., from the causes and on the date stated above.	
23a. SIGNATURE W. M. Moser (Degree or title) MD		23b. ADDRESS Cameron Mo	
23c. DATE SIGNED 12-24-53		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE 12-24-53		24c. NAME OF CEMETERY OR CREMATORY Amity	
24d. LOCATION (City, town, or county) (State) Amity Mo		25. FUNERAL DIRECTOR'S SIGNATURE John Bram ADDRESS Mayeville Mo	
DATE REC'D BY LOCAL REG. 1-6-53		REGISTRAR'S SIGNATURE Winifred W. Moser (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.....

working under my personal supervision.

Signed.....
Student Embalmer

Signed.....

Student Embalmer No.....

Licensed Embalmer No. 3933

P. O. Address Mayaville 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.