No. 300
10-48

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

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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED APR 7 1953

State File No. 12991

BIRTH NO. 39917 REG. DIST. NO. 340 PRIMARY REG. DIST. NO. 6151 Registrar's No. 13

1. PLACE OF DEATH
a. COUNTY Stoddard
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Elk. Rural
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri b. COUNTY Stoddard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Elk. (Rural) 1030
d. STREET ADDRESS (If rural, give location) Bernie Mo. Rt. 1

3. NAME OF DECEASED (Type or Print) a. (First) Brenda b. (Middle) Sue c. (Last) Williams

4. DATE OF DEATH (Month) (Day) (Year) Feb 17, 1953

5. SEX F
6. COLOR OR RACE W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) mp 0
8. DATE OF BIRTH June 16, 1952
9. AGE (In years last birthday) IF UNDER 1 YEAR Months 8 Days | IF UNDER 24 HRS. Hours | Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Bernie Rt. 1 Mo
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Verle Williams
13b. MOTHER'S MAIDEN NAME Jewell Nissonger
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) —
16. SOCIAL SECURITY NO. —
17. INFORMANT'S SIGNATURE OR NAME ADDRESS Carl Williams Parma Mo. Rt. 1

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

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchial Pneumonia — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Measles and Whooping Cough
DUE TO (c)

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 0850 C
20. AUTOPSY? YES ☐ NO ☐

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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb 7, 1953 *to* Feb 17, 1953 *that I last saw the deceased alive on* Feb 7, 1953, *and that death occurred at* 3:00 A m., *from the causes and on the date stated above.*

23a. SIGNATURE Dr. Geo. W. Kunsted (Degree or title) M.D.
23b. ADDRESS Parma Mo.
23c. DATE SIGNED 2/17/53

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 2/17/53
24c. NAME OF CEMETERY OR CREMATORY Taylor Cemetery
24d. LOCATION (City, town, or county) (State) 7 mi North Parma Mo

DATE REC'D BY LOCAL REG. 3/30/53
REGISTRAR'S SIGNATURE Velma N. Goodwin 409
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS

(Licensed Embalmer's Statement on Reverse Side)

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_____

Licensed Embalmer No._____

P. O. Address_____

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.