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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **35306**

FILED NOV 2 - 1953

BIRTH NO. _____ REG. DIST. NO. **61** PRIMARY REG. DIST. NO. **4107** Registrar's No. **59**

1. PLACE OF DEATH a. COUNTY Cedar		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission.) a. STATE Missouri b. COUNTY Cedar	
b. CITY OR TOWN El Dorado Springs		c. CITY OR TOWN El Dorado Springs 0201	
d. FULL NAME OF HOSPITAL OR INSTITUTION 804 South Blvd		d. STREET ADDRESS (If rural, give location) 804 South Blvd	

3. NAME OF DECEASED (Type or Print) Corla	a. (First)	b. (Middle)	c. (Last) McWilliams	4. DATE OF DEATH Oct 28 1953
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH June 25 1871	9. AGE (In years, last birthday) 82
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and State or Foreign Country) Cedar County, Mo. U.S.A.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Thomas Hubbard	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Deceased
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Ray McWilliams - El Dorado Springs	ADDRESS
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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, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 2 years
	ANTECEDENT CAUSES		
	DUE TO (b) Hypertensive Disease DUE TO (c) Diabetic Deafness		
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	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) (Min.)	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 **Oct 21, 1953** to **Oct 28, 1953**, that I last saw the deceased alive on **Oct 27, 1953**, and that death occurred at **9:30 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE R. D. Dinaway MD (Degree or title)	23b. ADDRESS 312 South Blvd	23c. DATE SIGNED Oct 29
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 10-30-53	24c. NAME OF CEMETERY OR CREMATORY Mount Cemetery Cedar County Mo.	24d. LOCATION (City, town, or county) (State)
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DATE REC'D BY LOCAL REG. OCT. 29, 1953	REGISTRAR'S SIGNATURE W. H. ...	25. FUNERAL DIRECTOR'S SIGNATURE Swain Brothers El Dorado Springs Mo.	ADDRESS
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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

May W. Pickering

Licensed Embalmer No. *4696*

P. O. Address *W. W. Pickering, Inc.*

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.