

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

State File No. **36541**

FILED NOV 13 1953

BIRTH NO. _____ REG. DIST. NO. 209 PRIMARY REG. DIST. NO. 3043 Registrar's No. 381

1. PLACE OF DEATH a. COUNTY Marion		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Mississippi	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Hannibal		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Wyatt	
d. FULL NAME OF HOSPITAL OR INSTITUTION Levering Hospital		d. STREET ADDRESS (If rural, give location) 0670 1	

3. NAME OF DECEASED (Type or Print)	a. (First) Lorene	b. (Middle) -	c. (Last) Williams	4. DATE OF DEATH (Month) (Day) (Year) 11 2 53
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 2-20-1881	9. AGE (In years last birthday) Months Days Hours Min. 72
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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	11. BIRTHPLACE (State or foreign country) Pittsfield Ill.	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Hamilton	13b. MOTHER'S MAIDEN NAME Fannie Thomas	14. NAME OF HUSBAND OR WIFE Albert Williams
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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 Mrs Lela Deverger New Canton, Ill
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial failure		acute
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Myocarditis DUE TO (c) Diabetes mellitus		10 yr 20 yr
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death Hypertension & debilitated		14 days	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 260X	20. AUTOPSY YES <input type="checkbox"/> NO <input 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) (Minute) 11/4/53 5:05 P.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 Nov 13, 1953 to 11/2, 1953, that I last saw the deceased alive on 11/2, 1953, and that death occurred at 5:05 P.M., from the causes and on the date stated above.

23a. SIGNATURE Wm. H. DeWitt	(Degree or title)	23b. ADDRESS W. H. DeWitt, Ill.	23c. DATE SIGNED 11/4/53
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 12/6/53	24c. NAME OF CEMETERY OR CREMATORY I.O.O.F Cemetery	24d. LOCATION (City, town, or county) (State) Charleston, Mo.
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DATE REC'D BY LOCAL REG. 11/4/53	REGISTRAR'S SIGNATURE H. C. Fisher Deputy	25. FUNERAL DIRECTOR'S SIGNATURE H. M. O'Donnell	ADDRESS Hannibal, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

0.300
0.48

NOV 9 1953

RECEIVED

MARION CO. HEALTH DEPT.

DATE FILED

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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 *H. M. O'Donnell*

Licensed Embalmer No. 3889

P. O. Address Hannib, o, Missouri

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.