

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

State File No. **7839**

FILED MAR 29 1954 REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. **314**

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
a. COUNTY Buchanan		a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph		c. LENGTH OF STAY (in this place) 50 yrs	
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph		d. STREET ADDRESS (If rural, give location) 205 Iowa St.	
d. FULL NAME OF HOSPITAL OR INSTITUTION 205 Iowa St.		e. STREET ADDRESS (If rural, give location) 205 Iowa St.	
3. NAME OF DECEASED		4. DATE OF DEATH	
a. (First) Nannie		(Month) (Day) (Year) Mar 19 1954	
b. (Middle) Williams		c. (Last) Williams	
5. SEX Female		6. COLOR OR RACE Negro	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH Oct. 15, 1876	
9. AGE (In years last birthday) 77		IF UNDER 1 YEAR 5 IF UNDER 1 MO. 5 IF UNDER 1 WKS. 5	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY n/a	
11. BIRTHPLACE (City and State or Foreign Country) Bethany, Mo.		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Charles Mason		13b. MOTHER'S MAIDEN NAME Unknown	
14. NAME OF HUSBAND OR WIFE August Williams		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. Unknown		17. INFORMANT'S SIGNATURE OR NAME August Williams	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* Acute Angina Pectoris		19. INTERVAL BETWEEN ONSET AND DEATH About 24 Hrs	
2. ANTECEDENT CAUSES Asphyxiation		3. DUE TO (b) Suffocation	
4. DUE TO (c) Spasms of the Coronary Arteries		5. II. OTHER SIGNIFICANT CONDITIONS old age, Hypotension (cardiac), & natural causes	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 4201	
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) 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 3/18/1954 8:30 AM , to 3/19/1954 4:00 PM , that I last saw the deceased alive on 3-18-1954 , and that death occurred at 9:00 A. M. , from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) Dr. Crin Murray Jr. M.D.		23b. ADDRESS 109 W. Moore St. Joseph, Mo.	
23c. DATE SIGNED 3-20-54		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE Mar 22, 1954		24c. NAME OF CEMETERY OR CREMATORY Ashland Cemetery	
24d. LOCATION (City, town, or county) (State) St. Joseph, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE Beatrice Galt	
DATE REC'D BY LOCAL REG. Mar 23, 1954		REGISTRAR'S SIGNATURE Kathleen M. Allison	
25. FUNERAL DIRECTOR'S SIGNATURE Beatrice Galt		ADDRESS 819 Pacific St. Joseph, Mo.	

(Licensed Embellisher's Statement on Reverse Side)

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

No. 300
10-48

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 Earn a Clark

Licensed Embalmer No. 4238

P. O. Address St. Joseph 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.