

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **8368**

BIRTH NO. **FILED MAR 17 1954** REG. DIST. NO. **132** PRIMARY REG. DIST. NO. **4203** Registrar's No. **41**

0400
1

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Grundy | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY Grundy | |
| b. CITY OR TOWN Galt | | c. CITY OR TOWN Galt | |
| c. LENGTH OF STAY (In this place) 10yr | | d. STREET ADDRESS (If rural, give location) | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION | | | |

| | | | | |
|---|----------------------------|-----------------------------|-----------|---|
| 3. NAME OF DECEASED (Type or Print) WILLIE | a. (First) HAMILTON | b. (Middle) WILLIAMS | c. (Last) | 4. DATE OF DEATH (Month) (Day) (Year) 3-8-1954 |
|---|----------------------------|-----------------------------|-----------|---|

| | | | | | | | | |
|-----------------|---------------------------|---|-----------------------------------|---|-----------------------|---------------------|-----------------------|----------------------|
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH 12-4-1876 | 9. AGE (In years last birthday) 77 | # UNDER 1 YEAR Months | # UNDER 1 YEAR Days | # UNDER 24 HRS. Hours | # UNDER 24 HRS. Min. |
|-----------------|---------------------------|---|-----------------------------------|---|-----------------------|---------------------|-----------------------|----------------------|

| | | | |
|--|---|--|---|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | 10b. KIND OF BUSINESS OR INDUSTRY Same | 11. BIRTHPLACE (City and State or Foreign Country) Morgan Co Ohio | 12. CITIZEN OF WHAT COUNTRY? USA |
|--|---|--|---|

| | | |
|---|--|---|
| 13a. FATHER'S NAME John R Williams | 13b. MOTHER'S MAIDEN NAME Mary Knight | 14. NAME OF HUSBAND OR WIFE Emma William Galt mo |
|---|--|---|

| | | | |
|---|-------------------------|--|------------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> | 16. SOCIAL SECURITY NO. | 17. INFORMANT'S SIGNATURE OR NAME Mrs Emma Williams | ADDRESS Galt 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 | | INTERVAL BETWEEN ONSET AND DEATH |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis | DUE TO (b) Benign Hypertension | sudden death 7 seconds |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) Unknown cause - patient seemed strongly nervous. | | 15 years |
| 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 4201 | 20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) (Min.) | 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 **July 1950**, to **3-8-1954**, that I last saw the deceased alive on **3-7-54**, 19__, and that death occurred at **2:00pm.**, from the causes and on the date stated above.

| | | |
|---|-----------------------------|---------------------------------|
| 23a. SIGNATURE A Walker Eitzbold (Degree or title) | 23b. ADDRESS Galt Mo | 23c. DATE SIGNED 3/10/54 |
|---|-----------------------------|---------------------------------|

| | | | |
|---|----------------------------|--|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24b. DATE 3-10-1954 | 24c. NAME OF CEMETERY OR CREMATORY Rural Dale Cem | 24d. LOCATION (City, town, or county) (State) Trenton Mo |
|---|----------------------------|--|---|

| | | | |
|---|---|---|------------------------|
| DATE REC'D BY LOCAL REG. 3-10-54 | REGISTRAR'S SIGNATURE J. J. J. '15 | 25. FUNERAL DIRECTOR'S SIGNATURE P. K. Payne | ADDRESS Galt mo |
|---|---|---|------------------------|

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 PK Payne

Licensed Embalmer No. 3400

P. O. Address Galt

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.