

FILED JUN 11 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 17627

No. 900  
10.48

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

BIRTH MO. _____		REG. DIST. NO. 335		PRIMARY REG. DIST. NO. 6118		Registrar's No. 18	
1. PLACE OF DEATH a. COUNTY <b>SCOTT</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MISSOURI</b> b. COUNTY <b>SCOTT</b>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>RURAL SYLVANIA TOWNSHIP</b>		c. LENGTH OF STAY (In this place) <b>2 yrs.</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>RURAL SYLVANIA TOWNSHIP</b>		1000	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>R. F. D. #1 ORAN</b>				d. STREET ADDRESS (If rural, give location) <b>R. F. D. #1 ORAN</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>ABE</b>		b. (Middle) _____		c. (Last) <b>WILLIAMS</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>MAY 23 1954</b>	
5. SEX <b>MALE</b> 2		6. COLOR OR RACE <b>COLORED</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>		8. DATE OF BIRTH <b>JUNE 14 1925</b>	
9. AGE (In years last birthday) <b>28</b>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <b>MISSISSIPPI</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13a. FATHER'S NAME <b>BEN WILLIAMS</b>		13b. MOTHER'S MAIDEN NAME <b>QUATILLA SPAIN</b>		14. NAME OF HUSBAND OR WIFE <b>ESTHER WILLIAMS</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>WORLD WAR #2 296-30-8427</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>ESTHER WILLIAMS R? F. D. #1 ORAN</b>			
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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Gunshot wound back of neck at close range</b>				INTERVAL BETWEEN ONSET AND DEATH <b>0</b>	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  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 _____				20. AUTOPSY? <b>E981 X</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>Homicide</b>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Base-line Road 4 m. W.</b>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>Rural - R.F.D. Morley - Scott Mo</b>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <b>1:30A m.</b> , from the causes and on the date stated above.							
23a. SIGNATURE <b>Thelma C. Buckthorpe M.D. Health Officer</b>				23b. ADDRESS <b>Benton, Mo</b>		23c. DATE SIGNED <b>5-26-54</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24b. DATE <b>MAY 26 1954</b>		24c. NAME OF CEMETERY OR CREMATORY <b>MCMULLAN CEMETERY</b>		24d. LOCATION (City, town, or county) (State) <b>SCOTT COUNTY MO.</b>	
DATE REC'D BY LOCAL REG. <b>6-5-54</b>		REGISTRAR'S SIGNATURE <b>Maufreylington</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Earl J. Smith</b>		ADDRESS <b>ORAN, MO.</b>	

Licensed Embalmer's Statement on Reverse Side

DATE RECEIVED JUN 7 1954  
SCOTT CO. HEALTH DEPT.  
CO. FILE No. 654-113

JUN 7 1954

JUN 9 1954

STATEMENT BY LICENSED EMBALMER

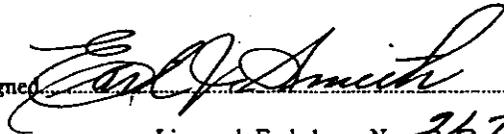
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Student Embalmer

Signed \_\_\_\_\_



Licensed Embalmer No. 2676

P. O. Address Owen, 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.