

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

BIRTH NO. _____ REG. DIST. NO. 43 PRIMARY REG. DIST. NO. 5143 Registrar's No. 459

| | | | | | |
|--|---|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Butler</u> | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>B utler</u> | | |
| b. CITY (If outside corporate limits, write RURAL and give township) <u>Poplar Bluff, Mo.</u> | | c. LENGTH OF STAY (in this place) | c. CITY OR TOWN <u>Poplar Bluff</u> | | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Hwy. 60 E.</u> | | | STREET ADDRESS (If rural, give location) <u>Hwy. 60 East Gypsy Camp</u> | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) <u>Johnnie</u> b. (Middle) _____ c. (Last) <u>Williams</u> | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 23, 1954</u> | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Gypsy</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u> | 8. DATE OF BIRTH <u>Aug. 20, 1930</u> | 9. AGE (In years last birthday) <u>24</u> | IF UNDER 1 YEAR Months _____ Days _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stove repair</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and State or Foreign Country) <u>Olkamulga, Okla.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> |
| 13a. FATHER'S NAME <u>Harry Williams</u> | | 13b. MOTHER'S MAIDEN NAME <u>Rosa Nicholes</u> | | 14. NAME OF HUSBAND OR WIFE <u>Unknown</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Harry Williams Poplar Bluff, Mo.</u> | | |
| 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, asthenia, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Gun shot wound left side</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>neck</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION <u>E981X</u> | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Homicide</u> | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Camp home</u> | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Poplar Bluff, Mo. Butler Mo</u> | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>Aug. 23-1954 7:16 P.M.</u> | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | 21f. HOW DID INJURY OCCUR? <u>Shot in neck with shot gun</u> | | | |
| 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 <u>7:15 P.M.</u> , from the causes and on the date stated above. | | | | | |
| 23a. SIGNATURE <u>Charles Wheeler</u> | | (Degree or title) <u>Coroner</u> | 23b. ADDRESS <u>Poplar Bluff, Mo.</u> | | 23c. DATE SIGNED <u>Aug 27-1954</u> |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 24b. DATE <u>8-27-54</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cem.</u> | 24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u> | | |
| DATE REC'D BY LOCAL REG. <u>8/28/54</u> | REGISTRAR'S SIGNATURE <u>R. N. Murrell</u> | 25. FUNERAL DIRECTOR'S SIGNATURE <u>429-0</u> | ADDRESS <u>Frank-Cotrell Poplar Bluff, Mo.</u> | | |

(Licensed Embalmer's Statement on Reverse Side)

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

FILED SEP 1 1954

RECEIVED
AUG 30 1954
BUTLER CO. HEALTH CENTER
FILE No. _____

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 _____
Signature of Student Embalmer

Signed *Charles W. Green*

Licensed Embalmer No. *2964*

P. O. Address *Indianapolis, Ind.*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.