

FILED SEP 28 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

29985

State File No. ....

BIRTH NO. .... REG. DIST. NO. 47 PRIMARY REG. DIST. NO. 3008 Registrar's No. 270

|  |  |   |  |   |   |   |   |  |  |
|--|--|---|--|---|---|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Callaway</u>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Saline</u> |   |   |   |  |  |
| b. CITY (If outside corporate limits, write RURAL and give township)<br><u>Fulton</u>  |  | c. LENGTH OF STAY (In this place)<br><u>8 yrs</u>   |  | c. CITY OR TOWN <u>Sweet Springs</u>  |   | d. Is Residence within limits of a city or incorporated town?<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |   |  |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>State Hospital #1</u>   |  |   |  | e. STREET ADDRESS (If rural, give location)<br><u>0970</u>  |   |   |   |  |  |
| 3. NAME OF DECEASED<br>(Type or Print)<br>a. (First) <u>Tom</u>  |  |   | b. (Middle)  |   | c. (Last) <u>Williams</u>   |   | 4. DATE OF DEATH<br>(Month) (Day) (Year)<br><u>Sept 21 1954</u> |  |  |
| 5. SEX <u>male</u>   |  | 6. COLOR OR RACE <u>Collored</u>  |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><u>widower</u>  |   | 8. DATE OF BIRTH<br><u>unknown</u>  |   | 9. AGE (In years last birthday)<br><u>80 ?</u><br>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)<br><u>Fram laborer</u>   |  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Farm</u>   |   | 11. BIRTHPLACE (City and State or Foreign Country) <u>Petitis Co, Missouri</u>          |   |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |  |
| 13a. FATHER'S NAME<br><u>Albert Williams</u>   |  |   | 13b. MOTHER'S MAIDEN NAME<br><u>Hattie Houston</u> |   |   | 14. NAME OF HUSBAND OR WIFE<br><u>unknown</u>   |   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>NO</u>  |  |   | 16. SOCIAL SECURITY NO.<br><u>None</u>             |   | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS<br><u>State Hospital Records, Fulton, Mo.</u> |   |   |  |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)  |  | MEDICAL CERTIFICATION   |  |   |   |   |   | INTERVAL BETWEEN ONSET AND DEATH   |  |
| *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.   |  | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic Myocarditis</u>                                     |  |   |   |   |   | <u>6 weeks</u>   |  |
|  |  | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. |  |   |   |   |   |  |  |
|  |  | DUE TO (b) <u>Arteriosclerosis</u><br>DUE TO (c) <u>Cerebral A ccident</u>  |  |   |   |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. MAJOR FINDINGS OF OPERATION<br><u>331X</u>   |  |   |   |   |   | 20. AUTOPSY?<br>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)  |  | 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 <u>July</u> , 19 <u>53</u> , to <u>Sept 21</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>Sept 21</u> , 19 <u>54</u> , and that death occurred at <u>9:20 Am</u> , from the causes and on the date stated above. |  |   |  |   |   |   |   |  |  |
| 23a. SIGNATURE (Degree or title)<br><u>[Signature]</u> M.D.  |  |   |  | 23b. ADDRESS<br><u>State Hospital, Fulton, Mo</u>   |   |   | 23c. DATE SIGNED<br><u>9/21/54</u>                              |  |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Removal</u>  |  | 24b. DATE<br><u>9-23-54</u>   |  | 24c. NAME OF CEMETERY OR CREMATORY<br><u>anatomical Board, Columbia</u>   |   | 24d. LOCATION (City, town, or county) (State)<br><u>mo</u>  |   |  |  |
| DATE REC'D BY LOCAL REG.<br><u>Sept 23-54</u>  |  | REGISTRAR'S SIGNATURE<br><u>Maretha Lawrence</u>  |  |   | 25. FUNERAL DIRECTOR'S SIGNATURE<br><u>J. D. Roberts</u>                                |   | ADDRESS<br><u>Columbia mo</u>                                   |  |  |

(Licensed Embalmer's Statement on Reverse Side)

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

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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.....  
Signature of Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.