

FILED JAN 26 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 2111

BIRTH NO. REG. DIST. NO. 290 PRIMARY REG. DIST. NO. 5985 Registrar's No. 8

1. PLACE OF DEATH a. COUNTY Pulaski		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Indiana b. COUNTY Daviess	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Fort Leonard Wood		c. CITY OR TOWN Washington	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION US Army Hospital		f. STREET ADDRESS (If rural, give location) Maxwell Avenue 0310	

3. NAME OF DECEASED (Type or Print) Anna		b. (Middle) Lou	c. (Last) Williams	4. DATE OF DEATH (Month) (Day) (Year) January 14, 1955	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH March 9, 1934	9. AGE (In years last birthday) 20
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) Washington, Indiana	
13a. FATHER'S NAME Paul Moffett		13b. MOTHER'S MAIDEN NAME Vi Tesort		14. NAME OF HUSBAND OR WIFE Thomas L. 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 ADDRESS ROBERT STALEY US Army Hospital ASC Ft Leonard Wood, Mo	
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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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary embolism  ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Phlebothrombosis pelvic veins DUE TO (c) Acute salpingitis  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Obesity 622X		INTERVAL BETWEEN ONSET AND DEATH 3 minutes  3-5 days  10 days	
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19a. DATE OF OPERATION 5 Jan 1955		19b. MAJOR FINDINGS OF OPERATION Acute suppurative salpingitis (organism undetermined)		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) (Minute)		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 4 January, 1955, to 14 January, 1955, that I last saw the deceased alive on 14 January, 1955, and that death occurred at 10:55 a.m., from the causes and on the date stated above.

23a. SIGNATURE CHURCH MURDOCK JR. (Degree or title) M.D.		23b. ADDRESS US Army Hospital Fort Leonard Wood, Missouri		23c. DATE SIGNED 14 Jan 1955	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 1-15-55		24c. NAME OF CEMETERY OR CREMATORY Unknown	
24d. LOCATION (City, town, or county) (State) Washington Indiana		24e. FUNERAL DIRECTOR'S SIGNATURE		24f. ADDRESS	
DATE REC'D BY LOCAL REG. 1-15-55		REGISTRAR'S SIGNATURE		25. FUNERAL HOME'S SIGNATURE ADDRESS	
		Edna E. Anderson		Hedges Funeral Homes Crocker, Mo	

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED 1-15-55  
Pulaski County Health Officer  
File Number  
Date Filed 1-23-55

### 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.....  
*Clarence D. Moore*

Licensed Embalmer No. 4891

P. O. Address *Waynesville*

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.