

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

27121

State File No.

FILED SEP 6 1955

BIRTH NO. _____		REG. DIST. NO. <u>250</u>		PRIMARY REG. DIST. NO. <u>4874</u>		Registrar's No. <u>n</u>	
1. PLACE OF DEATH a. COUNTY <u>NODAWAY</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>NODAWAY</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>CLYDE</u>		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN <u>CLYDE</u>		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 <u>BENEDICTING SISTERS OF PERPETUAL ADORATION</u>				No. STREET ADDRESS <u>BENEDICTING SISTERS OF PERPETUAL ADORATION</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>SISTER M. TERESA</u> b. (Middle) _____ c. (Last) <u>WILLIER</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>AUGUST 25 1955</u>				
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHT.</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>NEVER MARRIED</u>	8. DATE OF BIRTH <u>MAY 12, 1869</u>		9. AGE (In years last birthday) <u>86</u>	10. MONTHS <u>3</u>	11. DAYS <u>13</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SISTER</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <u>PEORIA, ILLINOIS</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>JOSEPH WILLIER</u>		13b. MOTHER'S MAIDEN NAME <u>HANORA WELCH</u>		14. NAME OF HUSBAND OR WIFE <u>NONE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT'S SIGNATURE OR NAME <u>BENEDICTING SISTERS OF PERPETUAL ADORATION</u> ADDRESS <u>CLYDE, 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, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebrovascular Accident</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>331XH</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2</u> <u>10 yrs</u> <u>2 yrs</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				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) _____		21f. HOW DID INJURY OCCUR? _____	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22. I hereby certify that I attended the deceased from <u>Nov 24, 1954</u> , to <u>Aug 25, 1955</u> , that I last saw the deceased alive on <u>Aug 25, 1955</u> , and that death occurred at _____ from the causes and on the date stated above.			
23a. SIGNATURE <u>[Signature]</u> (Degree or title) _____		23b. ADDRESS <u>Marionville, Mo</u>		23c. DATE SIGNED <u>8/29/55</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>AUG. 27, 1955</u>		24c. NAME OF CEMETERY OR CREMATORY <u>MT. CALVARY</u>		24d. LOCATION (City, town, or county) (State) <u>CLYDE, MISSOURI</u>	
DATE REC'D BY LOCAL REG. <u>Aug 31 - 55</u>		REGISTRAR'S SIGNATURE <u>Mrs. E. G. Crenshaw</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Stamberg, Mo.</u>			

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.....
Signature of Student Embalmer

Signed *James E. Johnson*

Licensed Embalmer No. *494*

P. O. Address *Stanherr*

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.