

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED SEP 19 1955

BIRTH NO. _____ REG. DIST. NO. 167 PRIMARY REG. DIST. NO. 1256 Registrar's No. 32

1. PLACE OF DEATH a. COUNTY Johnson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Johnson	
b. CITY (If outside corporate limits, write RURAL and give township) Holden		c. CITY (If outside corporate limits, write RURAL and give township) Kingsville	
c. LENGTH OF STAY (In this place) 2 weeks		d. STREET ADDRESS (If rural, give location) Missouri	
d. FULL NAME OF HOSPITAL OR INSTITUTION Holden Hospital			

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) William	b. (Middle) Clarence	c. (Last) WILLIAMS	(Month) Aug.	(Day) 16,	(Year) 1955
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH March 31, 1888		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocer		10b. KIND OF BUSINESS OR INDUSTRY Retail Food		11. BIRTHPLACE (City and State, or Foreign Country) Kingsville, Missouri	
13a. FATHER'S NAME James H. Williams			13b. MOTHER'S MAIDEN NAME Anna C. Paul		14. NAME OF HUSBAND OR WIFE Lovina Rudd Williams
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. ---		17. INFORMANT'S SIGNATURE OR NAME Mrs. Lovina Williams, Kingsville, Mo	
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) Hypostatic pneumonia		INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral Apoplexy					
DUE TO (c) Atherosclerosis					
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? 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) (Min.)		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 Jan 1, 1955 , to Aug 16, 1955 , that I last saw the deceased alive on Aug 15, 1955 , and that death occurred at 4:30 P.M. , from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) G. W. Moreland M.D.			23b. ADDRESS Holden Mo		23c. DATE SIGNED 8-17-55
24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE Aug. 18, 1955		24c. NAME OF CEMETERY OR CREMATORY Holden Cemetery	
24d. LOCATION (City, town, or county) (State) Holden Mo.		25. FUNERAL DIRECTOR'S SIGNATURE E. B. CAST ADDRESS HOLDEN MO			
DATE REC'D BY LOCAL REG. Aug 20, 1955		REGISTRAR'S SIGNATURE Mrs. H. O. Redford		25. FUNERAL DIRECTOR'S SIGNATURE E. B. CAST ADDRESS HOLDEN MO	

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

RECEIVED
AUG 23 1955
JOHNSON COUNTY HEALTH DE

JUN 12 1958

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 _____

E. B. Cant

Licensed Embalmer No. 4059

P. O. Address Hildon, 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.