

FILED NOV 14 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **35663**

BIRTH NO. _____ REG. DIST. NO. **328** PRIMARY REG. DIST. NO. **3073** Registrar's No. **59**

1. PLACE OF DEATH a. COUNTY SCOTT		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO b. COUNTY SCOTT	
b. CITY OR TOWN CHAFFEE	c. LENGTH OF STAY (in this place) 16 Mos.	c. CITY OR TOWN CHAFFEE	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 N. FRISCO ST.		STREET ADDRESS (If rural, give location) N. FRISCO ST. 10010	

3. NAME OF DECEASED (Type or Print) DOROTHY MAE WILLIAMS	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH NOV 1-1955	(Month) (Day) (Year)
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) W	8. DATE OF BIRTH AUG 26-1891	9. AGE (In years last birthday) 64	IF UNDER 1 YEAR Months 2 Days 5 IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK	10b. KIND OF BUSINESS OR INDUSTRY HOME	11. BIRTHPLACE (City and State or Foreign Country) CARLINVILLE ILL.		12. CITIZEN OF WHAT COUNTRY?	

13a. FATHER'S NAME GEORGE PROCTOR	13b. MOTHER'S MAIDEN NAME MARIA HANN BROWN	14. NAME OF HUSBAND OR WIFE EARL WILLIAMS
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. 490-24-6617	17. INFORMANT'S SIGNATURE OR NAME Mr. Earl Williams, Chaffee Mo ADDRESS

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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Probable Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH ?
	ANTECEDENT CAUSES Found dead in bed. No available medical record or history)		
	DUE TO (b) 		
	DUE TO (c) 		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 331x		

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)	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 **First call after death.** _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **about 1:00 PM.** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Holena C. Buehler, M.D. Health Officer.	23b. ADDRESS Benton Mo	23c. DATE SIGNED 11-3-55
24a. BURIAL, CREMATION, REMOVAL (Specify) B	24b. DATE 11-3-55	24c. NAME OF CEMETERY OR CREMATORY FORREST HILLS MEMORIAL GARDENS ORAN MO
24d. LOCATION (City, town, or county) (State)	25. FUNERAL DIRECTOR'S SIGNATURE Mr. Earl Williams ADDRESS CHAFFEE MO	
DATE REC'D BY LOCAL REG. 11-5-55	REGISTRAR'S SIGNATURE Thos Earl Buehler	

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

DATE RECEIVED NOV 7 1955
SCOTT CO. HEALTH DEPT.
CO. FILE No. 1155-242

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. 381
P. O. Address Cape Girardeau

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.