

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25738

State File No. _____

FILED JUL 18 1956

BIRTH NO. _____ REG. DIST. NO. 391 PRIMARY REG. DIST. NO. 6153 Registrar's No. 15

1. PLACE OF DEATH a. COUNTY Stoddard		2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission). a. STATE Missouri b. COUNTY Stoddard	
b. CITY (If outside corporate limits, write RURAL and give town or township) Bell City, R 1		c. CITY OR TOWN Bell City,	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION		e. STREET ADDRESS (If rural, give location) Bell City, Rural R. 1020	

3. NAME OF DECEASED (Type or Print) a. (First) Eudocia	b. (Middle) XXXXXX	c. (Last) Williams	4. DATE OF DEATH (Month) (Day) (Year) June 23, 1956
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH June 1, 1885
9. AGE (In years last birthday) 71		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (City and State or Foreign Country) Alabama
12. CITIZEN OF WHAT COUNTRY? U, S, A		13. FATHER'S NAME Elex Steward	
13b. MOTHER'S MAIDEN NAME Alice Steward		14. NAME OF HUSBAND OR WIFE Ollive Williams	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) XXXX	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Ollive Williams Bell City, R. 1	
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 6 days years. 1 year
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Atherosclerosis DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Hemiplegia, Post CVA			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 331X	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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 6-19-56, to _____, 19____, that I last saw the deceased alive on 6-14-56 and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE Stephen Fair	23b. ADDRESS Bloomfield Mo	23c. DATE SIGNED 6-27-56
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24a. BURIAL / CREMATION / REMOVAL (Specify) Burial	24b. DATE 6-28-56	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
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DATE REC'D BY LOCAL REG. 7-2-56	REGISTRAR'S SIGNATURE Bernice Moore	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Fred Smith 1212 Main St Berkestan, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

360

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 *Fred J. Smith*

Licensed Embalmer No. *4428*

P. O. Address *Wilmington,*

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.