

FILED OCT 8 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **30459**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 127 PRIMARY REG. DIST. NO. 3000 Registrar's No. 890

1. PLACE OF DEATH a. COUNTY <b>Greene</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Greene</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>Springfield</b>	c. LENGTH OF STAY (in this place) <b>34 years</b>	c. CITY OR TOWN <b>Springfield</b>	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 <b>St. Johns Hospital</b>		e. STREET ADDRESS (If rural, give location) <b>1225 N. Robberson</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>LEROY</b> b. (Middle) c. (Last) <b>WILLIAMS</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Sept. 30, 1956</b>		
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>28 Sept. 1890</b>	9. AGE (In years last birthday) <b>66</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dentist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
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13a. FATHER'S NAME <b>Patrick Williams</b>		13b. MOTHER'S MAIDEN NAME <b>Cynthia Winters</b>		14. NAME OF HUSBAND OR WIFE <b>Helen Williams</b>	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Helen Williams</b>		ADDRESS <b>Springfield, Mo.</b>	
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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				INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>	
		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* <b>(a) Hypertensive cardiovascular disease</b>					
		ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  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. <b>Obesity, jaundice's cirrhosis</b>					

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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)	
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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"/>		21f. HOW DID INJURY OCCUR?	
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22. I hereby certify that I attended the deceased from 9/26, 1954, to 9/30, 1956, that I last saw the deceased alive on 9/30, 1956, and that death occurred at 2:00P m., from the causes and on the date stated above.

23a. SIGNATURE <b>Helen O.T. Winters, M.D.</b>		(Degree or title) <input type="checkbox"/>		23b. ADDRESS <b>Springfield Mo.</b>		23c. DATE SIGNED <b>9/30/56</b>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>10/2/1956</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Maple Park</b>		24d. LOCATION (City, town, or county) (State) <b>Springfield Mo.</b>	
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DATE REC'D BY LOCAL REG. <b>10-2-56</b>		REGISTRAR'S SIGNATURE <b>Edith Williams</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>J.W. Klingner &amp; Co.</b>		ADDRESS <b>Spgrd. Mo.</b>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

BBB1 2 2 100

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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 *Glen S. Williams*.....

Licensed Embalmer No. *4651*.....

P. O. Address *Springfield*.....

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.