

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33446

STATE FILE NUMBER

FILED NOV 7 - 1956

Health,
& Welfare
Public
Service

Registration District No. 74 Primary Registration District No. 4136 Registrar's No. 43

1. PLACE OF DEATH a. COUNTY <u>Clinton</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clinton</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Plattsburg</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Plattsburg</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Quinn Rest Home</u>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>MAY</u> Middle <u>—</u> Last <u>Williams</u>			4. DATE OF DEATH Month <u>NOV.</u> Day <u>1</u> Year <u>1956</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 17 1886</u>	9. AGE (In years last birthday) <u>70</u> IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> IF UNDER 24 HRS.:	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home keeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>X</u>	11. BIRTHPLACE (City and state or country) <u>Clinton County Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Alexander Williams</u>			14. MOTHER'S MAIDEN NAME <u>Elizabeth Daniels</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>X</u>	17. INFORMANT <u>Fred Williams</u> Address <u>Plattsburg, MO.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>					INTERVAL BETWEEN ONSET AND DEATH <u>14 days 4 hrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					DUE TO (b) _____ DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? <u>4222</u> YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>Oct 1 - 56</u> and last saw her <u>Nov 1 - 56</u> and last saw him <u>Nov 1 - 56</u> Death occurred at <u>7:15 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>W. B. Shalding, MD</u> (Degree of title)			22b. ADDRESS <u>Plattsburg Mo.</u>		22c. DATE SIGNED <u>Nov 1 - 56</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>NOV. 3 1956</u>	23c. NAME OF CEMETERY OR CREMATORY: <u>GREEN LAWN</u>		23d. LOCATION (City, town, or county) (State) <u>Plattsburg Mo.</u>
24. FUNERAL DIRECTOR <u>D. D. LYON</u> ADDRESS <u>Plattsburg, MO.</u>		25. DATE RECD. BY LOCAL REG. <u>NOV 3 - 1956</u>		26. REGISTRAR'S SIGNATURE <u>Elizabeth Devarce</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

300
1-56

441-7

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 *Frederic E. Corne*
.....

Licensed Embalmer No. *499*

P. O. Address *Staten Island, N.Y.*

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.