

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED DEC 17 1956

State File No. **40688**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. **1313**

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo</b> b. COUNTY <b>Buchanan</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Joseph,</b>		c. LENGTH OF STAY (If in place) <b>50yrs</b>	c. CITY OR TOWN <b>St. Joseph</b>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>214 Texas Ave., SILVEY REST HOME</b>		e. STREET ADDRESS (If rural, give location) <b>214 Texas Ave.,</b>	

3. NAME OF DECEASED (Type or Print)	a. (First) <b>Robert</b>	b. (Middle) <b>Lee</b>	c. (Last) <b>Williams</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Dec 6, 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>Divorced</b>	8. DATE OF BIRTH <b>Sept. 21, 1871</b>	9. AGE (In years last birthday) <b>85</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours	IF UNDER 1 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Buchanan Co., Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Preston Williams</b>	13b. MOTHER'S MAIDEN NAME <b>Sarah Grace</b>	14. NAME OF HUSBAND OR WIFE <b>Elizabeth Triggs</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Charles Williams, DeKalb, Mo</b>	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Myocarditis</b>		unknown
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Pulmonary Fibrosis</b> DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<b>525.X</b>	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	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)
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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?
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22. I hereby certify that I attended the deceased from **Dec 23, 1953, to Dec 6, 1956**, that I last saw the deceased alive on **Nov 13, 1956**, and that death occurred at **7:40A.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Sharon E. Waggoner M.D.</b>	23b. ADDRESS <b>301 Illinois Ave St. Joseph, Missouri</b>	23c. DATE SIGNED <b>12-9-56</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>12/9/56</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Bethel Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>DeKalb, Mo</b>
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DATE REC'D BY LOCAL REG. <b>Dec 14, 1956</b>	REGISTRAR'S SIGNATURE <b>Eather M. Allison</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>John H. Keefe</b>	ADDRESS <b>St. Joseph, Mo</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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 *John E. Rupp*.....  
Licensed Embalmer No. *39*.....

P. O. Address *St. Joseph*.....

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.