

FILED AUG 27 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH30609
STATE FILE NUMBERRegistration District No. 360 Primary Registration District No. 3076 Registrar's No. 151

1. PLACE OF DEATH a. COUNTY Vernon		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Kansas b. COUNTY Pratt	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Nevada		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Pratt
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Nevada City Hospo		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 4150
			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Ann Middle Louise Last Williams			4. DATE OF DEATH Month 8 Day 22 Year 57		
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5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 10. 1957	9. AGE (In years last birthday) 2 Months 12 Days	IF UNDER 24 HRS. Hours 2 Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Hutchinson, Kansas	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Woodrow Williams	13b. MOTHER'S MAIDEN NAME Louis McCullough	14. NAME OF HUSBAND OR WIFE
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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)	16. SOCIAL SECURITY NO.	17. INFORMANT Nevada City Hospital, Nevada Mo.	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Menigitis		INTERVAL BETWEEN ONSET AND DEATH 3 days
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? 2 YES <input type="checkbox"/> NO <input checked="" 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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	Month, Day, Year
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20d. INJURY OCCURRED WHILE AT <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 _____
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21. I attended the deceased from Aug 20, 1957 to Aug 22, 1957 and last saw her alive on Aug 22, 1957 Death occurred at 11:55 A m on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE James P. Packer MD	(Degree or title)	22b. ADDRESS Nevada Mo.	22c. DATE SIGNED Aug 22, 1957
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 8-23-57	23c. NAME OF CEMETERY OR CREMATORY Greenlawn	23d. LOCATION (City, town, or county) Pratt, Kansas
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24. FUNERAL DIRECTOR Richard L. Shorten	ADDRESS Nevada, Mo.	25. DATE RECD. BY LOCAL REG. 8/23/1957	26. REGISTRAR'S SIGNATURE Arma J. Freese
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

0708

008

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 *Lloyd C. McLeod*

Licensed Embalmer No. *4853*

P. O. Address *Wanda*

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.