

DR JOHN WILLIAMS

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-036026

STATE FILE NUMBER

FILED NOV 3 1958 Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1022

S. 300
1-57

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY Pemiscot	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN CARUTHERSVILLE 0782
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION MERCY HOSPITAL		Length of stay in lb 18 MO.	d. STREET (If outside, give location) 1714 Chaffin Add.
3. NAME OF DECEASED (Type or print) First BERTHA Middle BOWMAR Last BOWMAR			4. DATE OF DEATH Month OCT , Day 24 , Year 1958
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL, 3, 1886
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME		10b. KIND OF BUSINESS OR INDUSTRY HOME	11. BIRTHPLACE (City and state or country) Unknown
13a. FATHER'S NAME Joe Markum		13b. MOTHER'S MAIDEN NAME Annie Garret	14. NAME OF HUSBAND OR WIFE X
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) NO		16. SOCIAL SECURITY NO. None	17. INFORMANT Address Jos. Hubert Simmons, Hayti, Mo.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Neuronhage of the brain DUE TO (b) arterio-sclerosis - generalize DUE TO (c) 331X Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
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? 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.)		
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____			
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
21. I attended the deceased from June 29-57 to Feb 24-58 and last saw her alive on 10/21/58 Death occurred at 2:45 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE John Williams M.D. Springfield (Degree or title)		22b. ADDRESS	22c. DATE SIGNED 10-25-58
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE Oct. 24/58	23c. NAME OF CEMETERY OR CREMATORY Maple Cemetery	23d. LOCATION (City, town, or county) (State) Caruthersville, Mo.
24. FUNERAL DIRECTOR HERMAN LOHMEYER		ADDRESS SPRINGFIELD, MO	25. DATE RECD. BY LOCAL REG. 10-28-58
26. REGISTRAR'S SIGNATURE Effie B. Melton			

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 *Gene Lohrey*

Licensed Embalmer No. *4734*

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.