

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-012319

STATE FILE NUMBER

FILED MAY 11 1959

Registration District No. 38

Primary Registration District No. 3006

Registrar's No. 206

300  
-57

1. PLACE OF DEATH a. COUNTY <u>Bronze</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Bronze</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Columbia</u> 0105 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>109 Oak St.</u>		Length of stay in lb <u>4 3/4</u>	d. STREET ADDRESS (If outside, give location) <u>109 Oak St</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>BERTIE</u> Middle <u>WILLIAMS</u> Last <u>WILLIAMS</u>			4. DATE OF DEATH Month <u>April</u> Day <u>30</u> Year <u>1959</u>		
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5. SEX <u>Female</u> <sup>3</sup>	6. COLOR OR RACE <u>negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 27-1879</u>	9. AGE (In years last birthday) <u>79</u>	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) <u>maiden</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Bronze Co. Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
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13a. FATHER'S NAME <u>Alfred Simpson</u>	13b. MOTHER'S MAIDEN NAME <u>Metilda Fisher</u>	14. NAME OF HUSBAND OR WIFE <u>Ben Williams</u>
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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) <u>no</u>	16. SOCIAL SECURITY NO.	17. INFORMANT <u>Edith Williams, 109 Oak St.</u> 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) <u>CEREBRAL ARTERIOSCLEROSIS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>MANY YRS</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>GENERALIZED ARTERIOSCLEROSIS</u>		<u>MANY YRS</u>
	DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>CHRONIC NEPHRITIS</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>
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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	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 _____
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21. I attended the deceased from <u>1-11-57</u> to <u>4-30-59</u> and last saw her/him alive on <u>4-15-59</u> Death occurred at _____ A _____ M on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>JOHN H. WAITES, M.D.</u> (Degree or title)	22b. ADDRESS <u>27 N 8th Columbia, Mo</u>	22c. DATE SIGNED <u>5-4-59</u>
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23a. BURIAL, CREMATION, REBURYAL (Specify) <u>Burial</u>	23b. DATE <u>May 5-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>C. Albany</u>	23d. LOCATION (City, town, or county) (State) <u>Columbia, Mo.</u>
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24. FUNERAL DIRECTOR <u>Mrs Stuart Parker, Columbia, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>May 4 1959</u>	26. REGISTRAR'S SIGNATURE <u>Mrs R E Palmer</u>
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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

MAY 18 1959

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 ..... *Georgette*

Licensed Embalmer No. *4770*  
P. O. Address *Marshall*

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.