

REGISTRATION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-020509

8 FILED JUL 13 1959 42 Primary Registration District No. 1000 Registrar's No. 707 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph	Length of stay in lb life	c. CITY OR TOWN St. Joseph	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Josephs Hosp.	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1015 Sylvania	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First BRADFORD Middle LEE Last WILLIAMS			4. DATE OF DEATH Month June Day 30 Year 1959		
---	--	--	--	--	--

5. SEX male	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3/26/1959	9. AGE (last birthday) _____	IF UNDER 1 YEAR Months 3 Days 4 Hours _____ Min. _____	IF UNDER 24 HR Hours _____ Min. _____
-----------------------	----------------------------------	---	--------------------------------------	---------------------------------	---	--

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) St. Joseph, Mo.	12. CITIZEN OF WHAT COUNTRY USA
---	-----------------------------------	--	---

13a. FATHER'S NAME Robert Williams	13b. MOTHER'S MAIDEN NAME Connie Strawn	14. NAME OF HUSBAND OR WIFE
--	---	-----------------------------

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 Robert Williams, 1015 Sylvania, St. Joseph, Mo	Address
--	-------------------------	--	---------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INTRACRANIAL BRAIN TUMOR.		INTERVAL BETWEEN ONSET AND DEATH None
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) 237X		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input checked="" 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.) 237X
--	---	---

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 St. Joseph	COUNTY Buchanan	STATE Mo.
---	--	--	---	---------------------------	---------------------

21. I attended the deceased from June 21, 1959 to June 30, 1959 and last saw her/him alive on June 30, 1959 Death occurred at 2:50 p. m on the date stated above, and to the best of my knowledge, from the causes stated.	
---	--

22a. SIGNATURE (Degree or title) William G. Lockhart M.D.	22b. ADDRESS 902 Edmund, St. Joseph, Mo.	22c. DATE SIGNED 1 July '59.
---	--	--

23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 7/2/1959	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	23d. LOCATION (City, town, or county) St. Joseph Mo.
--	------------------------------	---	--

24. FUNERAL DIRECTOR Heaton-Bowman	ADDRESS St. Joseph, Mo.	25. DATE RECD. BY LOCAL REG. July 8, 1959	26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell
--	-----------------------------------	---	--

DOCUMENT BY AFFIDAVIT OF MEDICAL CERTIFICATION W.S. Lockhart M.D.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____ Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Garth A. Smith

Licensed Embalmer No. 31927

P. O. Address 319 S. 10th St. St. Joseph, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.