

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-022120
STATE FILE NUMBER

FILED JUN 17 1959

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 1576

S. 300
v. 1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>Livingston Co</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Livingston</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Chillicothe</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Chillicothe</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>City Hospital</u>		Length of stay in lb <u>9 yrs.</u>	d. STREET ADDRESS (If outside, give location) <u>202 Jackson</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>ILA</u> Middle <u>I.</u> Last <u>WILLIAMS</u>			4. DATE OF DEATH Month <u>June</u> Day <u>9</u> Year <u>1959</u>
5. SEX <u>Fem.</u>	6. COLOR OR RACE <u>White</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 5, 1892</u>
9. AGE (In years last birthday) <u>66</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stenographer</u>	11. BIRTHPLACE (City and state or country) <u>LeRoy, Ills</u>
10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Robert Ingle</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Pence</u>	14. NAME OF HUSBAND OR WIFE <u>Eddie Williams</u>
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. <u>703-03-9330</u>	17. INFORMANT <u>Eddie Williams, Chillicothe, Mo.</u> 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) <u>acute coronary occlusion</u> 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) <u>Uremia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>7 day.</u>
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.	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		
21. I attended the deceased from <u>June 2-59</u> to <u>June 9-59</u> and last saw her ^{her} _{him} alive on <u>June 9-59</u> . Death occurred at <u>2:25 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Joseph F. Cole M.D.</u>		22b. ADDRESS <u>Chillicothe, Mo</u>	22c. DATE SIGNED <u>6-12-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>June 12, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Edgewood cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Chillicothe, Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Donald Gordon, Chillicothe, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>6/12/59</u>	26. REGISTRAR'S SIGNATURE <u>Frances B. Nell</u>

JUL 24 1959

6961 8 8 MAR

6961 7 1 1960

JUL 13 1962

MAR 2 1962

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 *Ronald Gordon*

Licensed Embalmer No. *4191*
P. O. Address *Chillicothe*

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.