

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH  
 FILED VS AUG 10 1959

59-024155

STATE FILE NUMBER

Registration District No. 38 Primary Registration District No. 3004 Registrar's No. 351

1. PLACE OF DEATH a. COUNTY <u>Boone</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Montgomery</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Length of stay in 1b <u>1 wk</u>	c. CITY OR TOWN <u>High Hill</u>		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>University Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>General Delivery</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Alma</u> Middle <u>William</u> Last <u>Williamson</u>			4. DATE OF DEATH Month <u>Aug</u> Day <u>8</u> Year <u>1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>4-27-'87</u>	9. AGE (last birthday) <u>72</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and state or country) <u>Warren Co. Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Miles William</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah Horton</u>		14. NAME OF HUSBAND OR WIFE <u>John Williamson</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>-</u>		17. INFORMANT <u>Hospital Record University Hosp.</u> Address <u>Columbia, Mo</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u>					
DUE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE</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)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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.)			
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. CITY, TOWN, OR LOCATION		20f. COUNTY		STATE
21. I attended the deceased from <u>8/2/59</u> to <u>8/8/59</u> and last saw her <sup>her</sup> <sub>him</sub> <u>live on</u> <u>8/7/59</u> Death occurred at <u>1:00 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>J J Sanders MD</u> (Degree or title)			22b. ADDRESS <u>Univ. of Mo. Med Center</u>		22c. DATE SIGNED <u>8/8/59</u> (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8-10-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mount Pleasant</u>		23d. LOCATION (City, town, or county) <u>High Hill Mo</u>	
24. FUNERAL DIRECTOR <u>Earl Harding Jones</u>		25. DATE RECD. BY LOCAL REG. <u>Aug 8 1959</u>		26. REGISTRAR'S SIGNATURE <u>Mrs R E Palmer</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

NOV 25 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  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Carl A. Hachberg

Licensed Embalmer No. 4115

P. O. Address Jonesburg

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.