

# URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-036538

FILED VS OCT 21 1959

STATE FILE NUMBER

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 441

RECEIVED

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Independence</u>		c. CITY OR TOWN <u>Oak Grove</u>	
Length of stay in 1b <u>2 Week</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>Independence + Sanitarium</u>		d. STREET ADDRESS (If outside, give location) <u>None</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Frieda</u> Middle <u>Marie</u> Last <u>Williams</u>			4. DATE OF DEATH Month <u>Oct</u> Day <u>4</u> Year <u>1959</u>			
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5. SEX <u>Female</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>June 3, 1901</u>	9. AGE (last birthday) <u>58</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HR Hours <u>  </u> Min. <u>  </u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and state or country) <u>Indianapolis Ind</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Detrick Rosebrock</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Perry 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. <u>None</u>	17. INFORMANT <u>Perry Williams</u> Address <u>Oak Grove Mo</u>
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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>Coronary Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10-5-59</u>
DUE TO (b) <u>  </u>		
DUE TO (c) <u>  </u>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetes Mellitus</u>	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
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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.) <u>  </u>
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20c. TIME OF INJURY Hour <u>  </u> Month, Day, Year <u>  </u>	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.) <u>  </u>	20f. CITY, TOWN, OR LOCATION <u>  </u> COUNTY <u>  </u> STATE <u>  </u>
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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.) <u>  </u>	20f. CITY, TOWN, OR LOCATION <u>  </u> COUNTY <u>  </u> STATE <u>  </u>
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21. I attended the deceased from 9-22-59 to 10-4-59 and last saw her alive on 10-4-59  
Death occurred at 4:15 PM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>J. W. Williams MD</u>	22b. ADDRESS <u>Oak Grove Mo</u>	22c. DATE SIGNED <u>10-5-59</u>
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23a. BURIAL (Cremation, Removal) (Specify) <u>Burial</u>	23b. DATE <u>10/7/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Cem</u>	23d. LOCATION (City, town, or county) (State) <u>Oak Grove Mo</u>
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24. FUNERAL DIRECTOR <u>Webb Funeral Home</u> ADDRESS <u>Mo</u>	25. DATE RECD. BY LOCAL REG. <u>10-7-59</u>	26. REGISTRAR'S SIGNATURE <u>James Craig</u>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by m

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed William J. Fran

Licensed Embalmer No. 4733

P. O. Address Blue Spring

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