

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-037002

FILED VS. NOV 6 1959 43

Registration District No. Primary Registration District No. 4264 Registrar's No. 36

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY <u>Newton</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Newton</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Stella Mo</u>		Length of stay in 1b <u>1 Week</u>		c. CITY OR TOWN <u>Fairview</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>Cardwell Memorial Hosnital</u>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) _____	
3. NAME OF DECEASED (Type or print) First <u>Susie</u> Middle <u>Williams</u> Last _____				4. DATE OF DEATH Month <u>Oct</u> Day <u>1</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>1/30/1886</u>	
9. AGE (last birthday) <u>73</u>		IF UNDER 1 YEAR Months <u>8</u> Days _____		IF UNDER 24 HR Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife in</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (City and state of country) <u>Washington Co. Mo.</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>							
13a. FATHER'S NAME <u>Richard Hendrix</u>			13b. MOTHER'S MAIDEN NAME <u>Martha Holloway</u>			14. NAME OF HUSBAND OR WIFE <u>George 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>None</u>		17. INFORMANT <u>Mrs Raymond Coatney, Fairview Mo</u>		
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 anoxia</u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u>
DUE TO (b) <u>Myocardial decompensation</u>							<u>3 days</u>
DUE TO (c) <u>Hypostatic pneumonia</u>							<u>5 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (but not related to the terminal disease condition given in PART I (a)) <u>Emac. surg. neck left femur - Smith's Artery Pin 9/25/59</u>							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 type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input checked="" 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>Fell on left hip.</u>			
20c. TIME OF INJURY Hour <u>2:30</u> a.m. _____ p.m. _____ <u>9 2259</u>		Month, Day, Year <u>at her home in Fairview, Mo.</u>					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>yard of home</u>		20f. CITY, TOWN, OR LOCATION <u>Fairview</u>		COUNTY <u>Newton</u> STATE <u>Mo</u>	
21. I attended the deceased from <u>9/24/59</u> to <u>10/1/59</u> and last saw her alive on <u>10/1/59</u> Death occurred at <u>2:50 P.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Fred R. Clark D.O.</u>				22b. ADDRESS <u>Box 96, Wheaton, Mo.</u>		22c. DATE SIGNED <u>10/2/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>10/4/1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Dice Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Fairview Mo</u>	
24. FUNERAL DIRECTOR <u>W. Morris Payne Wheaton, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>10-6-59</u>		26. REGISTRAR'S SIGNATURE <u>Mildred Moberly</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1959 NOV 9 SA

1959 NOV 7 SA

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

James Kenneth Hill

Licensed Embalmer No. 4767

P. O. Address Wheaton

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.