

Dr. W. W. Hurst

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-040637

STATE FILE NUMBER

FILED VS DEC 1 1959

Registration District No.

156

Primary Registration District No.

2001

Registrar's No.

560

V. S. 300  
Rev. 1-57

securing the medical certification in the specific manner required by 193.140 MoRS 1949.  
 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  
 MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Jasper</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>mo</u> b. COUNTY <u>Jasper</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Johlen</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Johlen</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>St. Johns Hospital</u>		Length of stay in 1b	d. STREET ADDRESS <u>123 1/2 Ave.</u> e. ADDRESS <u>798 1/2 ave.</u>
3. NAME OF DECEASED (Type or print) First <u>Nellie F</u> Middle <u>Williamson</u> Last			4. DATE OF DEATH Month <u>Nov</u> Day <u>17</u> Year <u>59</u>
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>Sept 26-1901</u>
9. AGE (Last birthday) <u>58</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (City and state or country) <u>Canton mo</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>Walter Horn</u>	
13b. MOTHER'S MARDEN NAME <u>Frances Horn</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 year or dates of service) <u>X</u>		16. SOCIAL SECURITY NO. <u>410-46-2469</u>	17. INFORMANT <u>John Williamson</u> Address <u>Baxter Springs 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>Cornary Occlusion Total Intubation</u>			INTERVAL BETWEEN ONSET AND DEATH
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)			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>4201</u>		
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____			
20d. INJURY OCCURRED WHILE AT <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 _____ and last saw her/him alive on _____ Death occurred at <u>4:50 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Wendell M. Tompkins</u> 3		22b. ADDRESS <u>Med Mt. Bldg. Joplin Mo</u>	22c. DATE SIGNED <u>11-14-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>11-17-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>West Rest Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Salina Kansas</u>
24. FUNERAL DIRECTOR <u>Home Wana Baxter Springs Mo</u>		25. DATE RECD. BY LOCAL REG. <u>11-25-1959</u>	26. REGISTRAR'S SIGNATURE <u>Dove Merriam</u>

MAY 18 1960

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 Wene Funeral Home, Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed J Lane Wene .....

Licensed Embalmer No. 2880 .....

P. O. Address Box 181 Kings Hwy .....

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.