

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-040815

FILED VS NOV 3 0 1959

STATE FILE NUMBER

Registration District No. 176 Primary Registration District No. 5656 Registrar's No. 19-

INDEXED

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY LA WRENCE	b. CITY (If outside corporate limits, give TOWNSHIP only) BOIS D ARC Ozark Sup	a. STATE MISSOURI	b. COUNTY LA WRENCE
Length of stay in 1b 5 DAYS		c. CITY OR TOWN HALLTOWN	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION R. E. D. 1		d. STREET ADDRESS (If outside, give location)	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First WILLIAM ALEXANDER	Middle HAMILTON	Last BIELLIER	4. DATE OF DEATH	Month NOV.	Day 21	Year 1959
-------------------------------------	-----------------------------------	---------------------------	-------------------------	------------------	----------------------	------------------	---------------------

5. SEX male	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH NOV 25 1867	9. AGE (last birthday) 91	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.
-----------------------	----------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------	----------------------------------------	-------------------------------------	---------------------------	------------------------	-------	------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER	10b. KIND OF BUSINESS OR INDUSTRY RETIRED	11. BIRTHPLACE (City and state or country) GREENE CO. MO.	12. CITIZEN OF WHAT COUNTRY U. S. A.
--------------------------------------------------------------------------------------------------------------	-----------------------------------------------------	---------------------------------------------------------------------	------------------------------------------------

13a. FATHER'S NAME C. D. BIELLIER	13b. MOTHER'S MAIDEN NAME MARGARET MEDSKER	14. NAME OF HUSBAND OR WIFE NANCY BIELLIER
---------------------------------------------	------------------------------------------------------	------------------------------------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT DEE BIELLIER	Address BOIS D ARC MO.
-----------------------------------------------------------------------------------------------------------------------	----------------------------------------	--------------------------------------	----------------------------------

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) CARDIAC COLLAPSE		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) MYO CARDITIS		
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 type="checkbox"/> No <input type="checkbox"/> Unknown
-----------------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------

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.)
---------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------

20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year
---------------------------------------------	------------------

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 NOV 14 - 1959 to NOV 21, 59 and last saw him alive on NOV. 21 - 59
Death occurred at 16:00 P. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE A.F. Slagp. Do	(Degree or title)	22b. ADDRESS Ash Grove Mo	22c. DATE SIGNED 11/22-59
-----------------------------------------	-------------------	-------------------------------------	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 11 23 1959	23c. NAME OF CEMETERY OR CREMATORY GAROUTTE CEMETERY	23d. LOCATION (City, town, or county) GREENE CO. MO.	(State)
------------------------------------------------------------	--------------------------------	----------------------------------------------------------------	----------------------------------------------------------------	---------

24. EMBALMER'S SIGNATURE W. Bush	ADDRESS ASH GROVE MO.	25. DATE RECD. BY LOCAL REG. 11-26-59	26. REGISTRAR'S SIGNATURE W. S. Berner
--------------------------------------------	---------------------------------	-------------------------------------------------	--------------------------------------------------

(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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Richard E. Watts

Licensed Embalmer No. 4652

P. O. Address Oak Grove

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.