

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-043081

FILED VS DEC 14 1959

STATE FILE NUMBER

Registration District No. 251 Primary Registration District No. 4513 Registrar's No. 117

ENDED

1. PLACE OF DEATH a. COUNTY <b>Sullivan</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Sullivan</b>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Green Castle</b>		Length of stay in 1b <b>Life</b>		c. CITY OR TOWN <b>Green Castle</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Home in Green Castle</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>No street address</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>Arvel Melvin Williams</b>				4. DATE OF DEATH Month <b>Dec.</b> Day <b>4,</b> Year <b>1959</b>									
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>4/15/1901</b>		9. AGE (last birthday) <b>58</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>General Farming</b>		11. BIRTHPLACE (City and state or country) <b>Green Castle, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>					
13a. FATHER'S NAME <b>Wallace H. Williams</b>				13b. MOTHER'S MAIDEN NAME <b>Arminta Broyles</b>				14. NAME OF HUSBAND OR WIFE <b>Gussie Williams</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>488-14-1069</b>		17. INFORMANT Address <b>Mrs. Gussie Williams, Green Castle,</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b>								INTERVAL BETWEEN ONSET AND DEATH <b>8 weeks</b>					
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)						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 <b>Oct 11-59</b> to <b>Dec 4-1959</b> and saw him alive on <b>Dec 3-1959</b> Death occurred at <b>7 a.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <b>H. Garrison</b> (Degree or title)				22b. ADDRESS <b>Springer</b>				22c. DATE SIGNED <b>Mo 12-4-59</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>12/6/1959</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Green Castle Cemetery</b>		23d. LOCATION (City, town, or county) <b>Green Castle Mo.</b>							
24. FUNERAL DIRECTOR <b>Glenn E. Felt</b> Address <b>Green City, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>12-8-59</b>		26. REGISTRAR'S SIGNATURE <b>Mrs. M. W. Beckett</b>							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JUL 29 1960

ITS  
AUG 8

**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 Karl R. Kent

Licensed Embalmer No. 4689

P. O. Address Green City, Mo.

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.