

**FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

'59 0 4 4 7 9 6

FILED VS. DEC 29 1959 215

Registration District No. Primary Registration District No. 5783 Registrar's No. 30

STATE FILE NUMBER

ENDED

|   |                                  |   |   |  |  |  |                              |
|---|----------------------------------|---|---|--|--|--|------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MILLER</b>  |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MISSOURI</b> b. COUNTY <b>MILLER</b>  |  |  |                              |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>LAKE-OZARK</b>  |                                  | Length of stay in 1b<br><b>Lifetime</b>   |   | c. CITY OR TOWN <b>LAKE-OZARK.</b>   |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |                              |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>LAKE-OZARK.</b>                                     |                                  |   |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |  | d. STREET ADDRESS (If outside, give location)<br><b>LAKE-OZARK.</b>  |                              |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Robert-</b> Middle <b>WILLIAMS</b> Last <b>WILLIAMS</b>                               |                                  |   |   | 4. DATE OF DEATH<br>Month <b>Dec</b> Day <b>14</b> Year <b>1959</b>  |  |  |                              |
| 5. SEX<br><b>MALE</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>24 APRIL-1889</b>            | 9. AGE (last birthday)<br><b>70</b>  | IF UNDER 1 YEAR<br>Months Days Hours Min.          |  | IF UNDER 24 HR<br>Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>FARMER.</b>                         |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Gen-Farming</b>   |   | 11. BIRTHPLACE (City and state or country)<br><b>MILLER-Co-Mo</b>  |  | 12. CITIZEN OF WHAT COUNTRY<br><b>U. S. A</b>  |                              |
| 13a. FATHER'S NAME<br><b>Alec-Williams-</b>   |                                  |   | 13b. MOTHER'S MAIDEN NAME<br><b>EMMA-James.</b>     |  |  | 14. NAME OF HUSBAND OR WIFE<br><b>Rachel-Williams</b>  |                              |
| 15. WAS DECEASED EVER IN U.S. ARMED SERVICES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>NO NONE</b>          |                                  | 16. SOCIAL SECURITY NO.<br><b>493-32-1541</b>   |   | 17. INFORMANT<br><b>Rachel-Williams- LAKE-OZARK Mo</b>   |  |  |                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:                              |                                  |   |   |  |  | INTERVAL BETWEEN ONSET AND DEATH   |                              |
| IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b>  |                                  |   |   |  |  | <b>undetermined</b>  |                              |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Coronary atherosclerosis</b> |                                  |   |   |  |  | <b>?</b>   |                              |
| DUE TO (c) <b>Anteroseptal</b>  |                                  |   |   |  |  | <b>?</b>   |                              |
| 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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |                              |
| 19. WAS AUTOPSY PERFORMED?<br>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.)<br><b>None</b>  |  |  |                              |
| 20c. TIME OF INJURY<br>Hour <b>4:30</b> a.m. <b>NONE</b> 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.)<br><b>None</b>  |  | 20f. CITY, TOWN, OR LOCATION<br><b>None</b>  |                              |
| 20e. COUNTY   |                                  | 20f. STATE  |   | 21. I attended the deceased from <b>9/22/59</b> to <b>12/8/59</b> and last saw him alive on <b>12/8/59</b> .<br>Death occurred at <b>9:30 A</b> m on the date stated above, and to the best of my knowledge, from the causes stated. |  |  |                              |
| 22a. SIGNATURE<br><b>N. Kaye</b> (Degree or title)  |                                  |   | 22b. ADDRESS<br><b>M.D. Jefferson-City-Mo</b>       |  |  | 22c. DATE SIGNED<br><b>12/15/59</b> (State)  |                              |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL-</b>   |                                  | 23b. DATE<br><b>12-16, 59</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New-Hope-</b>   |  | 23d. LOCATION (City, town, or county) (State)<br><b>Miller-Co-Mo</b>   |                              |
| 24. FUNERAL DIRECTOR<br><b>Keith M. Kaye</b> ADDRESS<br><b>ELDON-Mo</b>   |                                  |   | 25. DATE RECD. BY LOCAL REG.<br><b>Dec. 17-1959</b> |  | 26. REGISTRAR'S SIGNATURE<br><b>Jessie Perkins</b> |  |                              |

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 Keith M. Kays  
Licensed Embalmer No. 3998  
P. O. Address Eldon 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.