

FRI. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH  
 FILED VS MAR 14 1960

-60-006963

STATE FILE NUMBER

Registration District No. 160 Primary Registration District No. 559V Registrar's No. 78

1. PLACE OF DEATH a. COUNTY <u>JEFFERSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>JEF</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Festus</u>		Length of stay in 1b	c. CITY OR TOWN <u>O'Fallon</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mountain View N.H.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Woodlawn St</u>
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>MARCIA</u> Middle <u>WILLIAMS</u> Last <u>WILLIAMS</u>			4. DATE OF DEATH Month <u>Feb</u> Day <u>25</u> Year <u>1960</u>		
--	--	--	---	--	--

5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1871</u>	9. AGE (last birthday) <u>89</u>	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
----------------------	-------------------------------	--	------------------------------	----------------------------------	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>	11. BIRTHPLACE (City and state or country) <u>O'Fallon, MO</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
--	---	--	---

13a. FATHER'S NAME <u>J. W. Williams</u>	13b. MOTHER'S MAIDEN NAME <u>M. Boyd</u>	14. NAME OF HUSBAND OR WIFE <u>None</u>
--	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>Unk</u>	17. INFORMANT Address <u>Records Mt View N.H. Festus 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>Broncho-pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1WK.</u>
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 checked="" 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 <u>Sept 25 - 1957</u> to <u>2-25-60</u> and last saw her alive on <u>2-25-60</u> Death occurred at <u>3:20 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>R. D. Annell, M.D.</u>	22b. ADDRESS <u>Crystal City, MO</u>	22c. DATE SIGNED <u>2-26-60</u>
--	--------------------------------------	---------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2/28/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>OAK GROVE</u>	23d. LOCATION (City, town, or county) (State) <u>St Charles MO</u>
---	--------------------------	---	--

24. FUNERAL DIRECTOR ADDRESS <u>Keithly Funeral Home O'Fallon MO</u>	25. DATE RECD. BY LOCAL REG. <u>2/29/60</u>	26. REGISTRAR'S SIGNATURE <u>John N. Stoll Deputy</u>
--	---	---

DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

1-

**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 Ronald J. Mah

Licensed Embalmer No. 4975

R. O. Address Deoto,

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.