

# FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-019854

FILED VS JUN 7 1960

155 Primary Registration District No. 3127 Registrar's No. 93

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Jasper</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Jasper</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Webb City</b>	Length of stay in 1b <b>1 day</b>	c. CITY OR TOWN <b>Rural</b>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Jane Chinn Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>Rt. 1 Oronogo</b>
Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <b>Thomas</b> Middle <b>A.</b> Last <b>Williams</b>			4. DATE OF DEATH Month <b>May</b> Day <b>14</b> Year <b>1960</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>3-30-1894</b>	9. AGE (last birthday) <b>66</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
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	11. BIRTHPLACE (City and state or country) <b>Jasper Co. Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>		
13a. FATHER'S NAME <b>George W. Williams</b>		13b. MOTHER'S MAIDEN NAME <b>Elizabeth Williams</b>		14. NAME OF HUSBAND OR WIFE <b>Saleta 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>490-20-1575</b>	17. INFORMANT <b>Saleta Williams Rt. 1 Oronogo, Mo.</b>			

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) <b>Hepatorenal Syndrome</b>		<b>Unknown</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Ruptured Sigmoid</b>	<b>12 hours</b>
	DUE TO (c) <b>Strangulated Hernia</b>	<b>5 hours</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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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 **5-13-60** to **5-14-60** and last saw **DEK** him alive on **5-14 60**  
Death occurred at **5:30 P** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Gregory</i> (Degree or title) <b>D.O.</b>		22b. ADDRESS <b>Webb City, Missouri</b>		22c. DATE SIGNED <b>5-30-60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>5-17-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Hope Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Webb City, Mo.</b>	

24. FUNERAL DIRECTOR <b>Johnston-Simpson Mortuary</b> <b>Webb City, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>5-31-60</b>	26. REGISTRAR'S SIGNATURE <i>Mrs. Madeline Switzer</i>	
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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  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Jack C. Simpson*

Licensed Embalmer No. *4647*

P. O. Address *Webb City*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.