

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 12 1960

-60-030287

INDEXED

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 929 STATE FILE NUMBER

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| 1. PLACE OF DEATH a. COUNTY Greene | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Greene | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield | | Length of stay in 1b | c. CITY OR TOWN Springfield, Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Burge Hospital | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 1449 N. Grant Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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|---|----------------------------------|---|---|---|--|--|
| 3. NAME OF DECEASED (Type or print) First Mable Middle Z. Last Williams | | | 4. DATE OF DEATH Month September Day 4, Year 1960 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 12 Feb 1881 79 | 9. AGE (last birthday) 79 | 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) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Home | 11. BIRTHPLACE (City and state or country) Iowa | 12. CITIZEN OF WHAT COUNTRY USA | | |

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| 13a. FATHER'S NAME Charles Rue | | 13b. MOTHER'S MAIDEN NAME Unknown | 14. NAME OF HUSBAND OR WIFE Fred B. Williams |
| 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. ? | 17. INFORMANT Fred B. Williams (Husband) Springfield, Mo. |

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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Arteriosclerosis with multiple thrombi | | INTERVAL BETWEEN ONSET AND DEATH 12 mo. |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | |

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| 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 |
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| 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 9-18-52 to 9/4/60 and last saw her/him alive on 9/3/60
Death occurred at 12:40 A m on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE (Degree or title) D. M. K. Klingner M. D. | | 22b. ADDRESS 1630 N. Jefferson Springfield, Missouri | 22c. DATE SIGNED 9-6-60 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 9-6-60 | 23c. NAME OF CEMETERY OR CREMATORY Maple Park Cemetery | 23d. LOCATION (City, town, or county) (State) Springfield, Mo. |

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| 24. FUNERAL DIRECTOR KLINGNER MORTUARY, INC. SPRINGFIELD MO. | ADDRESS | 25. DATE RECD. BY LOCAL REG. 9-7-60 | 26. REGISTRAR'S SIGNATURE Effie S. Meelan |
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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SEP 13 1960

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 Glen D Williams

Licensed Embalmer No. 4651

P. O. Address Springfield

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.