

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-033961

FILED VS. OCT 17 1960 042

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STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Daviness</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b>		Length of stay in lb <b>1 Week</b>		c. CITY OR TOWN <b>Jameson</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>Missouri Methodist Hosp.</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Graham</b> Middle <b>Carlton</b> Last <b>Williams</b>				4. DATE OF DEATH Month <b>October</b> Day <b>5</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>Nov. 11, 1901</b>	9. AGE (last birthday) <b>58</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.
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>Farming</b>		11. BIRTHPLACE (City and state or country) <b>Daviness County</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13a. FATHER'S NAME <b>Rufus Williams</b>			13b. MOTHER'S MAIDEN NAME <b>Elizabeth Greer</b>			14. NAME OF HUSBAND OR WIFE <b>Opal 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>None</b>		17. INFORMANT <b>Mrs. Opal Williams</b> Address <b>Jameson Mo.</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>Chronic Myelogenous Leukemia</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 yr</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 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 <b>9:05 A.M.</b> Month, Day, Year <b>7-25-59</b>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION <b>Jameson</b>		COUNTY <b>Daviness</b> STATE <b>Missouri</b>	
21. I attended the deceased from <b>7-25-59</b> to <b>10-5-60</b> and last saw her alive on <b>Oct 5 '60</b> Death occurred at <b>9:05 A.M.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <b>Joseph L. Fisher m.d.</b>				22b. ADDRESS <b>702 Jule St.</b>		22c. DATE SIGNED <b>10-8-60</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Oct. 7, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>I.O.O.F. Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Pattonburg Missouri</b>				
24. FUNERAL DIRECTOR <b>Meinhardt Filander Inc. St. Joseph, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>Oct. 12, 1960</b>		26. REGISTRAR'S SIGNATURE <b>Wm. Clark Hardell</b>			

DOCUMENT

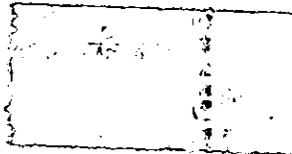
J.L. Fisher, M.D. MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ADA

(Licensed Embalmer's Statement on Reverse Side)

OCT 18 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 Robert C. Huntington

Licensed Embalmer No. 3258

P. O. Address St. Joseph

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.