

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

FILED VS NOV 15 1960

**-60-040710**

STATE FILE NUMBER

Registration District No. 323 Primary Registration District No. 6991 Registrar's No. 48

INDEXED

1. PLACE OF DEATH a. COUNTY <u>Saline</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Saline</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Salt Pond</u>		c. CITY OR TOWN <u>Sweet Springs</u>	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>in route To hospital</u>		d. STREET ADDRESS (If outside give location) <u>211 Daisy</u>	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Irene</u> Middle <u>MARIE K.</u> Last <u>Williams</u>			4. DATE OF DEATH Month <u>November</u> Day <u>9</u> Year <u>1960</u>		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>April 21 1924</u>	9. AGE (last birthday) <u>36</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HR Hours <u>  </u> Min. <u>  </u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and state or country) <u>Forrest Green Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Benjamin Kottman</u>	13b. MOTHER'S MAIDEN NAME <u>Ida Kramer</u>	14. NAME OF HUSBAND OR WIFE <u>James L. Williams</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>498-26-4402</u>	17. INFORMANT <u>James LeRoy Williams, Sweet Springs, Mo</u> Address
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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) <u>Cerebral Trauma</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>Compound Fracture of Skull</u> <u>15 min</u>
		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 checked="" type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <u>Auto accident</u>
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20c. TIME OF INJURY Hour <u>6:30</u> p.m. Month, Day, Year <u>11-9-60</u>
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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.) <u>Highway 90</u>	20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>LARAYETTE Co. Mo.</u>
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21. I attended the deceased from 1953 to 1960 and last saw her alive on 11-9-60  
Death occurred at about 6:50 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Charles D. Mohr, M.D.</u>	22b. ADDRESS <u>Sweet Springs, Mo</u>	22c. DATE SIGNED <u>11/10/60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Nov. 13, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fairview Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Sweet Springs Missouri</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Edgar L. Mowley, Sweet Springs Mo</u>	25. DATE RECD. BY LOCAL REG. <u>Nov. 11, 1960</u>	26. REGISTRAR'S SIGNATURE <u>Mr.</u>
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(Licensed Embalmer's Statement on Reverse Side)

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 me, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed Edgar L. Mowley  
Licensed Embalmer No. 4711  
P. O. Address Sweet Springs

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.