

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 5 1960

-60-041536

STATE FILE NUMBER

Registration District No. 106 Primary Registration District No. 570 Registrar's No. 12

1. PLACE OF DEATH a. COUNTY <u>Dunklin</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Dunklin</u>					
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Holcomb, Mo.</u>		Length of stay in 1b		c. CITY OR TOWN <u>Holcomb</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Rural Route, City</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Rural Route</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Beulah</u> Middle <u>Margaret</u> Last <u>Williams</u>				4. DATE OF DEATH Month <u>November</u> Day <u>20</u> Year <u>1960</u>					
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>8-29-1896</u>	9. AGE (last birthday) <u>64</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>21</u> Hours <u></u> Min. <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>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (City and state or country) <u>Greene Co., Ark.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>Robert Henry Brashers</u>			13b. MOTHER'S MAIDEN NAME <u>Martha Jane Rowe</u>			14. NAME OF HUSBAND OR WIFE <u>Charles Williams</u>			
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>none</u>		17. INFORMANT <u>Charles Williams, Holcomb, Mo.</u>				Address	
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>Terminal Hypostatic Pneumonia</u>							INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebro-Vascular accident - left hemiplegia</u>							<u>72 hrs.</u>		
DUE TO (c) <u>Hypertensive Cardio-Vascular disease</u>							<u>10+ years</u>		
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 <u></u> a.m. <u></u> p.m. <u></u>	Month, Day, Year <u></u>								
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>11/1/50</u> to <u>11/19/60</u> and last saw her <u>her</u> alive on <u>11/19/60</u> . Death occurred at <u>approximately 11:30p</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>Wallace A. Belsey M.D.</u>				22b. ADDRESS <u>Campbell Mo.</u>			22c. DATE SIGNED <u>11/23/60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11-22-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Ridge</u>		23d. LOCATION (City, town, or county) <u>Kennett Missouri</u>					
24. FUNERAL DIRECTOR <u>McDaniel Funeral Ser. Kennett, Mo.</u>			ADDRESS		25. DATE RECD. BY LOCAL REG. <u>11-26-1960</u>	26. REGISTRAR'S SIGNATURE <u>J. Anderson</u>			

(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 \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed D. L. Isbell

Licensed Embalmer No. 4970

P. O. Address Senath, ?

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.