

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

LED VS NOV 16 1960

60-041700
STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1102

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		Length of stay in 1b	c. CITY OR TOWN <u>Springfield</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>2627 N. Broadway</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>2627 N. Broadway</u>
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Burton</u> Middle <u>Oren</u> Last <u>Williams</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>2</u> Year <u>1960</u>			
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8-21-1881</u>	9. AGE (last birthday) <u>79</u>	IF UNDER 1 YEAR Months <u> </u> Days <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>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	11. BIRTHPLACE (City and state or country) <u>Webster Co., Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U S A</u>
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13a. FATHER'S NAME <u>Dr. William J. Williams</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Barnard</u>	14. NAME OF HUSBAND OR WIFE <u>Mava 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>none</u>	17. INFORMANT <u>Mrs. Mava Williams, Springfield, Mo.</u>
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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:		INTERVAL BETWEEN ONSET AND DEATH <u>time of death</u> <u>not known</u>
IMMEDIATE CAUSE (a) <u>Probable cerebral thrombosis</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Generalized Arteriosclerosis</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) <u>Cerebral thrombosis in Sept. 1960</u>	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 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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year _____
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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
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21. I attended the deceased from 10-15-59 to 11-2-60 and last saw ^{her}him alive on 9-25-60
Death occurred at 6:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Albert H. Simpson, M.D.</u>	(Degree or title)	22b. ADDRESS <u>25 Springfield Med Bldg Springfield, Mo.</u>	22c. DATE SIGNED <u>11-14-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11-4-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>	23d. LOCATION (City, town, or county) <u>Springfield, Mo.</u>	(State)
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24. FUNERAL DIRECTOR <u>Rex Rainey, Springfield, Mo.</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>11-14-60</u>	26. REGISTRAR'S SIGNATURE <u>Effie S. Melton</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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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 *W. C. Mason*

Licensed Embalmer No. 4560
P. O. Address *Spring*

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.