

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-046008

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 316 Primary Registration District No.        Registrar's No. 526

FILED JAN 11 1962

1. PLACE OF DEATH a. COUNTY <b>St. Francois</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Mississippi</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Francois Township</b>		Length of stay in 1b <b>2Y; 3M; 19das.</b>	c. CITY OR TOWN <b>Charleston</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>State Hospital #4</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>Route 2</b>
3. NAME OF DECEASED (Type or print) <b>Odell Williams</b>		4. DATE OF DEATH Month <b>December</b> Day <b>27</b> Year <b>1961</b>	

5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>5/20/1892</b>	9. AGE (last birthday) <b>69</b>	IF UNDER 1 YEAR Months <b>7</b> Days <b>7</b>	IF UNDER 24 HR Hours <b>      </b> Min. <b>      </b>
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>Georgia</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13a. FATHER'S NAME <b>Bascom Riley</b>		13b. MOTHER'S MAIDEN NAME <b>Missouri Grant</b>		14. NAME OF HUSBAND OR WIFE <b>Lonnie 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>-----</b>	17. INFORMANT <b>Records, State Hosp. #4, Farmington, Mo. &amp; Clara Ndsby, Rt. 2, Charleston, Missouri</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) **Cerebral hemorrhage** ----- **abt. 30 hrs.**

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) **Cerebral arteriosclerosis** ----- **Unknown.**

DUE TO (c) -----

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)  
**Psychosis with cerebral arteriosclerosis.**

PART III. If deceased was female was there a pregnancy in last 90 days.  
 Yes  No  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 <b>      </b> a.m. <b>      </b> p.m.	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 **Dec. 26, 1961** to **December 27, '61** and last saw her **Dec. 27, 1961** alive on **8:25 P.** m on the date stated above, and to the best of my knowledge, from the causes stated.  
Death occurred at  m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>John A. Brennan, MD</i>		22b. ADDRESS <b>State Hospital No. 4, Farmington, Missouri</b>		22c. DATE SIGNED <b>12-28-61</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>1/3/62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Charleston, Missouri</b>	
24. FUNERAL DIRECTOR <i>L. R. Sparks</i>		ADDRESS <b>Charleston, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>Dec. 28, 1961</b>	26. REGISTRAR'S SIGNATURE <i>Esther Rudloff</i>

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DATE RECEIVED

FILE NO.

**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 \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*Louis Robert Jones*

Licensed Embalmer No. 5132

P. O. Address Charleston

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.