

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**-62-001429**

STATE FILE NUMBER

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 24

AMENDED

**FILED FEB 5 1962**

1. PLACE OF DEATH a. COUNTY <u>Howell</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Howell</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>West Plains</u>		Length of stay in 1b <u>days</u>	c. CITY OR TOWN <u>West Plains</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>Memorial Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS <u>919 Grace</u> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Violet</u> Middle <u>Iola</u> Last <u>Reed</u>	4. DATE OF DEATH Month <u>Jan.</u> Day <u>21</u> Year <u>1962</u>
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5. SEX <u>F</u>	6. COLOR OR RACE <u>wht.</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8-5-1882</u>	9. AGE (last birthday) <u>79 yrs.</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>nurse</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Polk Co., Iowa</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>Yager Williams</u>	13b. MOTHER'S MAIDEN NAME <u>Elizabeth Williams</u>	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>yes</u>	17. INFORMANT <u>Mrs. Chas. Young, Pottersville, 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: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 DAYS</u>
DUE TO (b) <u>CEREBRAL HEMORRHAGE</u>		<u>10 DAYS</u>
DUE TO (c) <u>ARTERIOSCLEROSIS</u>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I. (a) <u>(1) Senility (2) Old Hip Fracture</u>	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
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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.) <u>—</u>
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	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 COUNTY _____ STATE _____
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21. I attended the deceased from <u>5-20-58</u> to <u>1-21-62</u> and last saw her alive on <u>1-21-62</u> Death occurred at <u>5:15 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>Joseph H. Wiles, M.D.</u>	22b. ADDRESS <u>West Plains, Mo.</u>	22c. DATE SIGNED <u>1-29-62</u>
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23a. BURIAL (Specify) <u>burial</u>	23b. DATE <u>1-24-1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Crider Cemetery</u>	23d. LOCATION (City, town, or county) <u>Crider, Mo.</u>	(State) _____
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24. FUNERAL DIRECTOR <u>Robertsons, West Plains, Mo.</u>	ADDRESS _____	25. DATE RECD. BY LOCAL REG. <u>2-1-1962</u>	26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 DATE AMENDED  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 BY AFFIDAVIT OF  
 ITEM NO. SHOULD READ

**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



Licensed Embalmer No. 3432

P. O. Address West Plains, Mo.

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.