

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-005513

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 93

FILED FEB 19 1962

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <u>Boone</u>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		a. STATE <u>Mo.</u>		b. COUNTY <u>Dunklin</u>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>University of Mo. Medical Center</u>		Length of stay in 1b <u>15 days</u>		c. CITY OR TOWN <u>Hornersville</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <u>Mittie</u> Middle <u>Williams</u> Last <u>James</u>		4. DATE OF DEATH		Month <u>2-</u> Day <u>12-</u> Year <u>62</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>10-27-11</u>	9. AGE (last birthday) <u>50</u>	IF UNDER 1 YEAR		IF UNDER 24 HR
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>Home</u>		11. BIRTHPLACE (City and state or country) <u>McCotey, Ark.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13a. FATHER'S NAME <u>Oscar Williams</u>			13b. MOTHER'S MAIDEN NAME <u>Mag. Batchar</u>		14. NAME OF HUSBAND OR WIFE <u>Jessie James</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>[Redacted]</u>		17. INFORMANT <u>Medical Records</u> Address <u>University of Mo. Med. Center Columbia, Mo</u>		
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>							
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							
DUE TO (b) <u>Hemorrhage</u>							
DUE TO (c) <u>Operation on Ovarian Cancer</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 type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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>[Blank]</u> a.m. <u>[Blank]</u> p.m. <u>[Blank]</u>		Month, Day, Year <u>[Blank]</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.) <u>[Blank]</u>		20f. CITY, TOWN, OR LOCATION <u>[Blank]</u>		COUNTY <u>[Blank]</u>	STATE <u>[Blank]</u>
21. I attended the deceased from <u>1-26-62</u> to <u>2-12-62</u> and last saw her/him alive on <u>2-12-62</u> . Death occurred at <u>11:55</u> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>H. Petera Ekern, M.D.</u>				22b. ADDRESS <u>Univ. Hosp. Columbia</u>		22c. DATE SIGNED <u>2-12-62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2-15-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Wanner Cemetery</u>		23d. LOCATION (City, town, or county) <u>Hornersville</u>		23e. (State) <u>Mo</u>	
24. FUNERAL DIRECTOR <u>[Signature]</u>			25. DATE RECD. BY-LOCAL REG. <u>Feb 14 1962</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. R.E. Palmer</u>		

DATE AMENDED
INSTEAD OF
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
ITEM NO. SHOULD READ

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 _____, Student Embalmer No. _____
working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed *James D. Emerson*

Licensed Embalmer No. 5148

P. O. Address Kennett, 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.