

OURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-007492

STATE FILE NUMBER

AMENDED

Registration District No. 278 Primary Registration District No. 3054 Registrar's No. 42

FILED MAR 8 1962

1. PLACE OF DEATH a. COUNTY <u>PIKE</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>PIKE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>LOUISIANA</u>		c. CITY OR TOWN <u>LOUISIANA</u>	
Length of stay in 1b <u>57-Yrs</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>LOUISIANA NURSING HOME</u>		d. STREET ADDRESS (if outside, give location) <u>130 FRANKFORD RD.</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>KATHERINE S WILLIAMS</u>	4. DATE OF DEATH Month Day Year <u>MAR 3 62.</u>
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5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</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>2-28-1874</u>	9. AGE (last birthday) <u>88</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, but if retired) <u>HOUSE WIFE</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	11. BIRTHPLACE (City and state or country) <u>CLARK Co MO</u>	12. CITIZEN OF WHAT COUNTRY <u>USA.</u>
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13a. FATHER'S NAME <u>DAVID CONLEY</u>	13b. MOTHER'S MAIDEN NAME <u>MILLIE GILLETTE</u>	14. NAME OF HUSBAND OR WIFE <u>JOHN 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>ELIZABETH SCOTT, LOUISIANA</u>	Address <u>DEC</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
IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>		
DUE TO (b) <u>Atherosclerotic Heart Disease</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)		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 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 12/1/61 to 3/3/62 and last saw her alive on 3/3/62
Death occurred at 5-40 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>John K. Helcomb</u>	22b. ADDRESS <u>M.D. 122 S. 3rd, Louisiana, Mo.</u>	22c. DATE SIGNED <u>3/3/62</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL 3-5-62.</u>	23b. DATE <u>3-5-62.</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SUMMER HILL CEM</u>	23d. LOCATION (City, town, or county) (State) <u>SUMMER HILL ILL</u>
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24. FUNERAL DIRECTOR <u>GEO. M. COLLIER LOUISIANA Mo</u>	25. DATE RECD. BY LOCAL REG. <u>Mar 5-62</u>	26. REGISTRAR'S SIGNATURE <u>Bernice Collier</u>
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

MAR 9 1962

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. _____

P. O. Address _____

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.