

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-045549

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 324 Primary Registration District No. 3092 Registrar's No. 230

DO NOT WRITE ON THIS STUB

AMENDED

FILED NOV 26 1962

VS 300  
Rev. 4/59

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20975

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

1. PLACE OF DEATH a. COUNTY <u>Saline</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Saline</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Marshall</u>			Length of stay in lb <u>one week</u>		c. CITY OR TOWN <u>Marshall</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>William Post Home</u>				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>431 Arrow</u>	
3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>Webb</u> Last <u>Williams</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>21</u> Year <u>1962</u>			
5. SEX <u>male</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>1-1-1873</u>	9. AGE (last birthday) <u>89</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>dairy farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>farming</u>		11. BIRTHPLACE (City and state or country) <u>Grant County Kentucky</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>
13a. FATHER'S NAME <u>John A. Williams</u>			13b. MOTHER'S MAIDEN NAME <u>Nancy Baxter</u>			14. NAME OF HUSBAND OR WIFE <u>Florence Hill</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>none</u>		17. INFORMANT Address <u>Mrs. Karl Griffith Overland Park, Kans.</u>		
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>Chr. nephritis &amp; Anemia</u>						<u>4 yrs.</u>	
DUE TO (b) <u>Chr. myocarditis</u>						<u>5 yrs.</u>	
DUE TO (c) <u>Generalized arteriosclerosis</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 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 _____ a.m. _____ p.m.		Month, Day, Year					
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 <u>Nov 1960</u> to <u>11-21-62</u> and last saw <u>him</u> alive on <u>11-20-62</u> Death occurred at <u>5:00 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Dr. M. C. Burrey, M.D.</u> (Degree or title)				22b. ADDRESS <u>Slater, Mo.</u>			22c. DATE SIGNED <u>11/23/62</u> (State)
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county)		
<u>Buried</u>			<u>Slater City Cemetery</u>		<u>Slater, Missouri</u>		
24. FUNERAL DIRECTOR <u>Braun Funeral Home</u>			ADDRESS <u>Slater, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>11-23-62</u>	26. REGISTRAR'S SIGNATURE <u>Cecil H. Reed</u>		

USE BLACK INK OR TYPEWRITER RIBBON

**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 Robert D. Braun

Licensed Embalmer No. 5183

P. O. Address Shelton, 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.