

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-027558

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 25 Primary Registration District No. 5th 3011 Registrar's No. 74

DO NOT WRITE ON THIS STUB
AMENDED

FILED AUG 5 1963

| | |
|---------------------|--------------|
| VS 300 Rev. 4/59 | DATE AMENDED |
| 1 <u>0171</u> | |
| 2 <u>20450</u> | |
| 3 | |
| 4 <u>1</u> | |
| 5 <u>2</u> | |
| 6 | |
| 7 <u>0</u> | |
| 8 <u>0</u> | |
| 9 <u>9420.1</u> | |
| 10 | |
| 11 | |
| 12 <u>90-2</u> | |
| 13 <u>2-0</u> | |

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Carroll | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Howard | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Carrollton | | c. CITY OR TOWN Fayette | |
| Length of stay in 1b 1 yr. | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 919 N. Park Street. | | d. STREET ADDRESS (If outside, give location) R.F.D. | |
| Yes <input type="checkbox"/> No <input type="checkbox"/> | | Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Daisy Belle Williams | | 4. DATE OF DEATH Month July Day 26 Year 1963. | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 4-9-1880 |
| 9. AGE (last birthday) 83 | | IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Keeping House | | 10b. KIND OF BUSINESS OR INDUSTRY House Work. | |
| 11. BIRTHPLACE (City and state or country) Miami Station Mo. | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13a. FATHER'S NAME George Hattabaugh. | | 13b. MOTHER'S MAIDEN NAME Rebecca Turner | |
| 14. NAME OF HUSBAND OR WIFE Samuel Williams (Dec) | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) no no | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT Miss Edna Walden (Carrollton Mo) | |
| 18. CAUSE OF DEATH (Enter only one cause for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction Chronic Myocarditis Arteriosclerosis | | INTERVAL BETWEEN ONSET AND DEATH Immediate 5 yrs 5 to 10 yrs | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) | | 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 | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input 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 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 July 1-63 to July 26-63 and last saw her alive on July 24-63 . Death occurred at Carrollton Mo on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE Edna Walden | | 22b. ADDRESS Waverly Mo | |
| 22c. DATE SIGNED 7-27-63 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 7-28-63. | 23c. NAME OF CEMETERY OR CREMATORY Miami Cemetery | 23d. LOCATION (City, town, or county) (State) Old Miami Mo. |
| 24. FUNERAL DIRECTOR Marshall F. Home | | 25. DATE RECD. BY LOCAL REG. 7-28-63 | 26. REGISTRAR'S SIGNATURE Mary Dean |
| ADDRESS Carrollton Mo. | | | |

USE BLACK INK OR TYPEWRITER RIBBON

AUG 22 1963

Handwritten notes:
Lidman
Sept 2
Sept 12

Handwritten signature:
R. M. Marshall

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 R. M. Marshall

Licensed Embalmer No. 2525

P. O. Address Carrollton Mo.

Handwritten notes:
W-10
2-22

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.