

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-035505

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 74 Primary Registration District No. 4136 Registrar's No. 440

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

DATE AMENDED

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

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SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Clinton</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clinton</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Plattsburg</u>		Length of stay in: b <u>3 mos.</u>	c. CITY OR TOWN <u>Lathrop</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>317 W. Locust St.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Not listed</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY BEATRICE WILLIAMS</u>			4. DATE OF DEATH Month Day Year <u>9 17 1963</u>
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>7-18-1889</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOMEMAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	9. AGE (last birthday) <u>74</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.
13a. FATHER'S NAME <u>MARCUS L. BOWMAN</u>		13b. MOTHER'S MAIDEN NAME <u>NANCY WATSON</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>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>		17. INFORMANT Address <u>Estil Williams Lathrop Mo.</u>	
DUE TO (b) <u>Cerebral hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>50 min</u>	
DUE TO (c)		<u>48 hrs.</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 Month, Day, Year a.m. p.m.		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>1961</u> to <u>1963</u> and last saw ^{her} <u>him</u> alive on <u>9-16-63</u> Death occurred at <u>9:15 p.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Estil Williams, D.O.</u>		22b. ADDRESS <u>Lathrop, Missouri</u>	22c. DATE SIGNED <u>9-17-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>9-20-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lathrop Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Lathrop Mo.</u>
24. FUNERAL DIRECTOR <u>BAILEY FUNERAL HOME Lathrop Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>9-18-63</u>	26. REGISTRAR'S SIGNATURE <u>Mary W Searee</u>

OCT 2 1963

OCT 30 1963

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 Mami Bailey

Licensed Embalmer No. 4887

P. O. Address Lathrop Ave

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.