

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

67 0019898

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 273 Primary Registration District No. 3051 Registrar's No. 60

FILED MAY 16 1967

1. PLACE OF DEATH a. COUNTY <u>PERRY</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>PERRY</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>PERRYVILLE</u>		c. CITY OR TOWN <u>PERRYVILLES</u>	
Length of stay in 1b <u>23 DAYS</u>		Inside Limits Yes ☒ No ☐	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>PERRY & MEMORIAL HOSP</u>		d. STREET ADDRESS (If outside, give location) <u>MORRIS NURSING HOME</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MAGGIE M WILLIAMS</u>		4. DATE OF DEATH Month Day Year <u>MAY 8 1967</u>	
5. SEX <u>FM</u>	6. COLOR OR RACE <u>W</u>	7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐	8. DATE OF BIRTH <u>9-4-1889</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11a. BIRTHPLACE (City and state or country) <u>ST. FRANCIS CO</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>HENRY KELLIN</u>		13b. MOTHER'S MAIDEN NAME <u>ELIZ. THOMPSON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT Address <u>FREDERICKTOWN</u> <u>NELLIE SHAW 100 S. ALBANY MO</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) <u>Coronary occlusion</u> DUE TO (c) <u>Coronary Artery Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Pneumonia</u> PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown			
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒		20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐		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>1966</u> to <u>5/8/67</u> and last saw her alive on <u>5/8/67</u> Death occurred at <u>7:30 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>A. E. McDermott, MD</u>		22b. ADDRESS <u>Berryville, Mo. 63775</u>	
22c. DATE SIGNED <u>5/11/67</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVED</u>	
23b. DATE <u>5-8-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CHRISTIAN HIGDON</u>	
23d. LOCATION (City, town, or county) <u>MADISON CO. MO.</u>		24. FUNERAL DIRECTOR ADDRESS <u>RAY WILSON FREDERICKTOWN MO</u>	
25. DATE RECD. BY LOCAL REG. <u>5-13-67</u>		26. REGISTRAR'S SIGNATURE <u>Joel Zallner</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DATE AMENDED

VS 300
Rev. 4/59

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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 Raymond B. Wilson

Licensed Embalmer No. 4884

P. O. Address Fredericktown 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.