

FILED JAN 22 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH44983
REGISTRATION NUMBERRegistration District No. 336 Primary Registration District No. 6131 Registrar's No. 392

1. PLACE OF DEATH a. COUNTY <u>Shannon</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Shannon</u>						
-b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Inside Limits</u> <u>On the Side Township</u> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Mtn. View, Mo.</u> 1010 Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Inside Limits		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>None - Home</u>			Length of stay in lb <u>61 yrs.</u>		d. STREET ADDRESS (If outside, give location) <u>Star Route</u>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Edley</u> Last <u>Widner</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>24</u> Year <u>1956</u>						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 10, 1873</u>		9. AGE (In years last birthday) <u>83</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>		11. BIRTHPLACE (City and state or country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>				
13. FATHER'S NAME <u>Samuel Widner</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Kester</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.		17. INFORMANT <u>Mrs. Frank Miller - Summersville, Mo.</u>				Address	
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>Conjunctive Circulatory Failure</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Decompensated Hypertensive heart disease</u> DUE TO (c) <u>Arteriosclerosis</u>								INTERVAL BETWEEN ONSET AND DEATH		
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 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 <u>4:30</u> Month <u>3</u> Day <u>3</u> Year <u>1956</u> a. m. <u>4:30</u> 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>1954</u> to <u>1956</u> and last saw her/him alive on <u>Oct 12 - 1956</u> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.										
22a. SIGNATURE (Degree or title) <u>Dr. Lawrence Hamilton D.O.</u>				22b. ADDRESS <u>Summersville Mo</u>				22c. DATE SIGNED <u>1-16-56</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Dec. 26, 1956</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oakside Cemetery</u>		23d. LOCATION (City, town, or county) <u>Mtn. View, Mo.</u>		(State)		
24. FUNERAL DIRECTOR <u>Duncan Funeral Home - Mtn. View, Mo.</u>				ADDRESS <u>1-21-57</u>		25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE <u>Michael R...</u>		

(Licensed Embalmer's Statement on Reverse Side)

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diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was examined
by me, or by, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *John F. Duncan*.....

Licensed Embalmer No *20*

P. O. Address *Memphis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
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.