

**JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-041374**

**FILED VS DEC 15 1959** 448

Registration District No. 448 Primary Registration District No. 6024 Registrar's No. 151

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <u>RAY</u>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>LAWSON</u>		a. STATE <u>MISSOURI</u>		b. COUNTY <u>RAY</u>	
Length of stay in lb <u>3 YEARS</u>		c. CITY OR TOWN <u>LAWSON</u>		d. STREET ADDRESS (If outside, give location) <u>ST NOT LISTED</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>ST NOT LISTED</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAMSON FRANKLINSON ALBERZON</u>				4. DATE OF DEATH Month Day Year <u>DEC 2 1959</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>FEB 20 1885</u>	9. AGE (last birthday) <u>74</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>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BUILDING</u>		11. BIRTHPLACE (City and state or country) <u>LAWSON, MO</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>WILLIAMSON E. ALBERZON</u>			13b. MOTHER'S MAIDEN NAME <u>DELIA H. J. WILSON</u>			14. NAME OF HUSBAND OR WIFE <u>SALLY NELSON</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>496-04-3492</u>		17. INFORMANT Address <u>MRS SALLY ALBERZON, LAWSON, MO</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>Coronary occlusion</u>						<u>10'</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arterio sclerosis</u>							
DUE TO (c)							
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>2 Dec 1959</u> to <u>2 Dec 1959</u> and last saw <u>him</u> alive on <u>Death on arrival</u> . Death occurred at <u>8:25 am</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>George E Sanders MD</u>				22b. ADDRESS <u>Excelsior Springs, Mo.</u>		22c. DATE SIGNED <u>3 Dec 59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>December 4 '59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LAWSON</u>		23d. LOCATION (City, town, or county) (State) <u>LAWSON, MISSOURI</u>		
24. FUNERAL DIRECTOR ADDRESS <u>JARMAN FUNERAL HOME, LAWSON, MO</u>				25. DATE RECD. BY LOCAL REG. <u>12-7-1959</u>		26. REGISTRAR'S SIGNATURE <u>Mabel Jackson</u>	

(Licensed Embalmer's Statement on Reverse Side) Ray Co. Cooner Antifid

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MS DEC 17 1959

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

~~or by~~ \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed Ralph Van Landingham

Licensed Embalmer No. 4009

P. O. Address Geekio Springs

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.