

NOV 21 1938

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

34716  
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399  
 (b) Township Law Primary Registration District No. 1007 Registered No. 4052  
 (c) City W. O. Mo. (d) Street No. General Hospital #2 St. \_\_\_\_\_  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

452 Aaron Williams  
 (a) Residence, No. 1614 1/2 Stout Ave. St.  (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Unknown

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 10-2-1885

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
53 5

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Unknown  
 9. Industry or business in which work was done, as saw mill, bank, etc. Unknown  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Saline 0

FATHER 13. NAME Unknown 9

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown 0

MOTHER 15. MAIDEN NAME Annie Thompson

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Saline

17. INFORMANT (ADDRESS) Record Clerk General Hospital

18. BURIAL, CREMATION, OR REMOVAL PLACE Blue Ridge Lawn DATE 10-18

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Doyle Bros Fun Home  
1708 T. Road

20. FILED Oct 17, 1938 M. M. Browne  
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10-7 1938

22. I HEREBY CERTIFY, That I attended deceased from 9-1 1938 to 10-7 1938

I last saw him alive on 10-7 1938. Death is said to have occurred on the date stated above, at 6:30 a.m.  
 The principal cause of death and related causes of importance were as follows:

Uterine  
Febrile  
 Date of onset \_\_\_\_\_

Other contributory causes of importance: 54B

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_ 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
 If so, specify \_\_\_\_\_  
 (Signed) J. A. Cooper M. D.  
 (Address) General Hospital #2

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

**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 .....

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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 this body is not embalmed, above space should be left blank.**