

REC'D FEB 21 1939

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

1663
Do not use this space.

1. PLACE OF DEATH

(a) County BUCHANAN Registration District No. 85
(b) Township WASHINGTON Primary Registration District No. 1001
(c) City ST. JOSEPH, (d) Street No. 2604 LAFAYETTE SR. 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 64 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME JESSIE FLORENCE WILLIAMSON

(a) Residence, No. 2604 LAFAYETTE St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX FEMALE 4. COLOR OR RACE WHITE 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) WIDOWED

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF J. W. WILLIAMSON

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) SEPTEMBER 12, 1874

7. AGE YEARS 64 MONTHS 4 DAYS 8 If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. HOUSEWIFE
9. Industry or business in which work was done, as saw mill, bank, etc. HOME
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) DONIPHAN COUNTY, KANSAS

FATHER 13. NAME WM. B. CHAMBERS

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) CITKA Co. ALABAMA

MOTHER 15. MAIDEN NAME SARAH E. BAKER,

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) CALLOWAY Co. MISSOURI

17. INFORMANT (ADDRESS) SARAH S. GINTER, ST. JOSEPH, MISSOURI.

18. BURIAL, CREMATION, OR REMOVAL PLACE ASHLAND CEMETERY, DATE JAN, 23, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) FLEEMAN & SON, INC. 1946 COLHOUN ST. ST. JOSEPH, MO.

20. FILED Jan 20 1939 A. J. Fretwell Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) JAN, 20, 1939 19

22. I HEREBY CERTIFY, That I attended deceased from 1-18, 1939, to 1-19, 1939. I last saw h. ER. alive on Jan. 19, 1939. Death is said to have occurred on the date stated above, at 12:05 A.M.
The principal cause of death and related causes of importance were as follows:

Pneumonia
Chronic arthritis
myocarditis
Nulseration of leg.
Date of onset 1-18-39

Other contributory causes of importance: _____
Name of operation _____ Date of _____
What test confirmed diagnosis? Clinical Was there an autopsy? No

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? No
If so, specify _____ (Signed) Thos. Richmond M. D.
(Address) 328. Kirkpatrick Bldg

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, JOHN E. RUPP

....., or by

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

Signed.....

John E. Rupp

Licensed Embalmer No. 3986

P. O. Address 1946 CQLHOUN ST.
ST. JOSEPH, MISSOURI.

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.