

REC'D FEB 21 1939

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

2224
Do not use this space.

1. PLACE OF DEATH

(a) County Franklin Registration District No. 293
(b) Township St. James Primary Registration District No. 5411 Registered No. _____
(c) ~~City~~ near St. James (A) Street No. _____ 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. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

433 BERTHA WILLIAMS
(a) Residence, No. ST JAMES MO 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) SINGLE
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF SINGLE
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) JUNE 11 1915
7. AGE YEARS 23 MONTHS 8 DAYS 2 If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
9. Industry or business in which work was done, as saw mill, bank, etc. At 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) Royal Mo.

FATHER
13. NAME J. F. Williams

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Royal Mo.

MOTHER
15. MAIDEN NAME Effie Murphy

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) TEA. Mo.

17. INFORMANT (ADDRESS) Mrs Effie Stillier
ST JAMES MO

18. BURIAL, CREMATION, OR REMOVAL
PLACE Funerary Home DATE 2/14 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) John L. Cope
St. James Mo.

20. FILED 2-17 1939 Mary B. Hoop
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-13-1939

22. I HEREBY CERTIFY, That I attended deceased from Jan 3, 1939, to Feb 13, 1939
Last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.
The principal cause of death and related causes of importance were as follows:

Broncho-pneumonia
1070
Other contributory causes of importance: Bronchial asthma
Date of onset Feb 1st 39

Name of operation _____ Date of _____
What test confirmed diagnosis? Ray 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? No
If so, specify _____
(Signed) Paul C. Stillier, M. D.
(Address) St. James, Mo

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.