

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.

REC'D MAR 8 1939

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

6143
Do not use this space.

1. PLACE OF DEATH

(a) County Carroll Registration District No. 135
(b) Township _____ Primary Registration District No. 3010 Registered No. 28
(c) City Carrollton (d) 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. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Donnis Williams

(a) Residence, No. _____ 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 F. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 24, 1863

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
75 2 29

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. at home
9. Industry or business in which work was done, as saw mill, bank, etc.
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) Bloomfield Iowa

FATHER 13. NAME Isaac Foster
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) England

MOTHER 15. MAIDEN NAME Martin
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Iowa

17. INFORMANT (ADDRESS) Mrs Marwin Collier Carrollton Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Williams Cem DATE Feb. 24, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Stanley Carrollton Mo

20. FILED 2-24 1939 W. H. Haskins Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 22, 1939

22. I HEREBY CERTIFY, That I attended deceased from Feb 15, 1939 to Feb 22, 1939
I last saw her alive on 2-22-39, 1939 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:

Pneumonia at home 108 1930
Bronchial Catarrh
Date of onset 2-15-39

Other contributory causes of importance: _____

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) A. B. Deaver M. D.
(Address) Carrollton, Mo

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,

Ben W. Gibson

....., or by

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

Signed.....

Ben W. Gibson

Licensed Embalmer No. *296 P*

P. O. Address *Carrollton, Me*

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.