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 MAY 19 1939

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

15879
Do not use this space.

1. PLACE OF DEATH
(a) County Randolph — Registration District No. 735
(b) Township — Primary Registration District No. 3034 — Registered No. 72
(c) City Moberly — (d) Street No. Woodland Hospital 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 Margaret Williamson
(a) Residence, No. 122 Kirby St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: William Williamson
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)
7. AGE: YEARS 73 | MONTHS | DAYS | If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Athome
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) Pa

FATHER
13. NAME Casper Foose
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Pa

MOTHER
15. MAIDEN NAME Elizabeth Cross
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Pa

17. INFORMANT (ADDRESS) William Williamson Moberly Mo
18. BURIAL, CREMATION, OR REMOVAL PLACE Moberly, Mo DATE Apl 9th 1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Mahan and Son Moberly Mo
20. FILED Apr 9 1939 Leah Williams Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 8th 1939
22. I HEREBY CERTIFY, That I attended deceased from Feb 17, 1939, to April 8, 1939
I last saw her alive on April 8, 1939. Death is said to have occurred on the date stated above, at 8:15 a.m.
The principal cause of death and related causes of importance were as follows:

Cerebral Hemorrhage with left Hemiplegia — Date of onset

82 Ul

Other contributory causes of importance: general Senility

Name of operation None Date of
What test confirmed diagnosis? Clinical 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 None
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify
(Signed) Paul C. Davis, M. D.
(Address) Moberly, Mo.

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
File Number 10-39-915
Date Filed MAY 18 1939

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 Frank D DeWitt

Licensed Embalmer No. 3021

P. O. Address Moberly Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp with the above constitutes grounds for revocation of license.)

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