REC'D AUG 18 1939

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

26212
Do not use this space.

1. PLACE OF DEATH
(a) County: Marion | Registration District No.: 547
(b) Township: Marion | Primary Registration District No.: 3029 | Registered No.: 206
(c) City: Hannibal | (d) Street No.: Deaconing 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: 15 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 452 Nettie Williams
(a) Residence, No.: 408 S. Arch 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): Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: —
6. DATE OF BIRTH (MONTH, DAY, AND YEAR): July 9, 1889
7. AGE: YEARS 50 | MONTHS — | DAYS — | If LESS than 1 day, ...hrs. or ...min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.: Shoe Inspector
9. Industry or business in which work was done, as saw mill, bank, etc.: International Shoe Co.
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): New Canton, Illinois

FATHER
13. NAME: James Williams
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Indiana

MOTHER
15. MAIDEN NAME: May Fylley
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): White Hall, Illinois

17. INFORMANT (ADDRESS): Ada Williams, Hannibal Mo.
18. ~~BURIAL, CREMATION, OR~~ REMOVAL PLACE: New Canton, Ill. DATE: July 11, 1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS): Roy P. Schurt, Hannibal Mo.
20. FILED: July 10, 1939 H. C. Fisher Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): July 9, 1939
22. I HEREBY CERTIFY: That I attended deceased from April 24, 1939, to July 9, 1939
I last saw him alive on July 9, 1939. Death is said to have occurred on the date stated above, at 2:00 a.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Lobar pneumonia	

Other contributory causes of importance:
Fractured right Hip

Name of operation: None 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) Bernard L. Murphy M. D.
(Address) Hannibal Mo.

(Licensed Embalmer's Statement on Reverse Side)

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.

1142

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, ...
Cecil E. Schwartz, or by .....
Registered Apprentice No. 2338, working under my personal supervision.

Signed Cecil E. Schwartz

Licensed Embalmer No. 2338

P. O. Address Hannibal, Mo

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

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

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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1. PLACE OF DEATH
(a) County Marion — Registration District No. 547
(b) Township — Primary Registration District No. 3029 — Registered No.
(c) City Hannibal — (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 Nettie Williams
(a) Residence, No. — 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: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): S
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)
7. AGE: YEARS 50 — MONTHS — DAYS — 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.
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)

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

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

17. INFORMANT (ADDRESS)
18. BURIAL, CREMATION, OR REMOVAL
PLACE — DATE — 19
19. FUNERAL DIRECTOR (ADDRESS)
20. FILED — 19 — Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-9, 1939
22. I HEREBY CERTIFY, That I attended deceased from ....., 19.... to ....., 19....
I 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:
Lobar Pneumonia — Date of onset
186 W
Other contributory causes of importance:
Fractured Rt Hip
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? acc. — Date of injury 4-23, 1939
Where did injury occur? Hannibal, Marion Co. - mo. (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. in home
Manner of injury fell at home
Nature of injury fr. right hip -
24. Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) Bernard L. Murphy M. D.
(Address) Hannibal Mo.

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

1939
5-26212