

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

Dr. J. James:

43393

Do not use this space.

1. PLACE OF DEATH
 (a) County GREENE Registration District No. 316
 (b) Township SPRINGFIELD Primary Registration District No. 2001
 (c) City SPRINGFIELD (d) Street No. St. John Hosp. Registered No. 923
 (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 Infant Daughter Mr. Mrs. Lester Williams
 (a) Residence, No. 963 S. Jefferson 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 <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Dec. 20, 1939</u>				
7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>0</u>	<u>0</u>	<u>0</u>	<u>3</u>
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	
FATHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Springfield Missouri</u>			
	13. NAME <u>Lester Williams</u>			
MOTHER	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Missouri</u>			
	15. MAIDEN NAME <u>Opal Kirby</u>			
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Missouri</u>				
17. INFORMANT (ADDRESS) <u>Lester Williams Springfield, Mo.</u>				
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Eastlawn</u> DATE <u>Dec. 21, 1939</u>				
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>H.H. Lohmeyer Springfield, Missouri</u>				
20. FILED <u>12/21, 1939</u> <u>Char. A. George, M.D.</u> Local Registrar.				

MEDICAL CERTIFICATE OF DEATH

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

22. I HEREBY CERTIFY, That I attended deceased from Dec 20, 1939, to Dec 20, 1939
 I last saw her alive on Dec 20, 1939. Death is said to have occurred on the date stated above, at 5 P.M.
 The principal cause of death and related causes of importance were as follows:
Premature 29th wk.
154
 Other contributory causes of importance:
Hepatic (mother)

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) Joseph J. James, M. D.
 (Address) Springfield 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.

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.

X