

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

REG FEB 13 1940

Registration District No. 318

Primary Registration District No. 2001

Registrar's No. 27

1. PLACE OF DEATH:
 (a) County Greene
 (b) City or town Springfield
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution 986 N. Jefferson
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 23 years (Specify whether years, months or days) 11501

8. (a) PRINT FULL NAME FRANCES CORDELIA WILLIAMS
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White
 6. (a) Single, widowed, married, divorced Widow
 6. (b) Name of husband or wife Columbus P. Williams
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased March 9, 1859
 (Month) (Day) (Year)

8. AGE: Years 80 Months 9 Days 29
 If less than one day _____ hr. _____ min.

9. Birthplace Dallas County Missouri
 (City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business _____
 12. Name Samuel L. Clines
 13. Birthplace Tennessee
 (City, town, or county) (State or foreign country)
 14. Maiden name Lydia Sumpter
 15. Birthplace Tennessee
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Mrs. M. H. Gray
 (b) Address 986 N. Jefferson
 17. (a) Burial (b) Date thereof Jan 10, 1940
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Mt. Pleasant Burial, Mo

18. (a) Signature of funeral director H. C. Christian
 (b) Address Springfield, Mo
 19. (a) 1/9/40 (b) Chas. H. George
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Greene
 (c) City or town Springfield
 (If outside city or town limits, write "RURAL")
 (d) Street No. 986 N. Jefferson
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 8
 year 1940 hour 3:45 minute _____ A. M.
 21. I hereby certify that I attended the deceased from Jan 15, 1939 to Jan 8, 1940,
 that I last saw her alive on 1 - Jan 7, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death
1. Uterus, sclerosis, general
2. Toxic psychosis
 Due to Senility
 Due to _____
 Other conditions (Include pregnancy within 3 months of death) _____

Duration 10-20 yrs
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically

Major findings:
 Of operations _____
 Of autopsy _____

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____
 23. Signature A. M. White (M. D. or other) M.D.
 Address Springfield, Mo Date signed 1/8/40

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.....

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

Signed *Ralph Thime*.....

Licensed Embalmer No. *3681*.....

P. O. Address *Sp. Mo.*.....

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