

FILED MAR 14 1940

Registration District No. **7**

Primary Registration District No. **5005**

Registrar's No. **35**

1. PLACE OF DEATH:

(a) County **Adair Mo. To 2**  
 (b) City, or town **Country**  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: **2**  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution **2**  
(Specify whether  
 In this community **11 5 7**  
years, months or days)

3. (a) PRINT FULL NAME **FRANKLIN WILLIAMS**

3. (b) If veteran, name war: \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex **male** 5. Color or race  **white** 6. (a) Single, widowed, married, divorced \_\_\_\_\_

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased **mar 30 1939**  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**10 15** hr. min.

9. Birthplace **Adair Co Mo**  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
 { 12. Name **Ruben Williams**  
 { 13. Birthplace **Adair Co Mo**  
(City, town, or county) (State or foreign country)  
 { 14. Maiden name **Edna Furch**  
 { 15. Birthplace **Adair Co Mo**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Ruben Williams**  
 (b) Address **Wells Mo N. E. D. 6**

17. (a) \_\_\_\_\_ (b) Date thereof **Feb 16 1940**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation **Green Castle**

18. (a) Signature of funeral director **Sumner Pluedgen**  
 (b) Address **Merksville Mo**

19. (a) **2-27-40** (b) **Spencer L. Heeman**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Adair**  
 (c) City or town **Merksville Mo. Rural**  
(If outside city or town limits, write "RURAL")  
 (d) Street No. **Benton Tp.**  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb** day **15**  
 year **1940**, hour **1**, minute **30 P.M.**

21. I hereby certify that I attended the deceased from **Feb 11-40**  
**Feb 14** 19**40** to **Feb 17** 19**40**  
 that I last saw **him** alive on **Feb 14** 19**40**  
 and that death occurred on the date and hour stated above.

Immediate cause of death **Stroke**  
**Primum**

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions **Primum**  
(Include pregnancy within 3 months of death)

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? \_\_\_\_\_

3 While at work? \_\_\_\_\_ (Specify type of place)  
 (e) Means of injury \_\_\_\_\_

23. Signature **Spencer L. Heeman** (M. D. or other) \_\_\_\_\_  
 Address **Merksville Mo** Date signed **2/16/40**

Duration  
 PHYSICIAN  
 Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

107A  
RECEIVED

District Health Officer No. 10

District File Number 3-40-596

Date Filed MAR 12 1940

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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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 57497

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 4

Primary Registration District No. 5005-

Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Adair

(b) City or town Benton Sup.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. (Specify whether

In this community years, months or days)

3. (a) Franklin Williams

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex m (5. Color or race white)

6. (b) Name of husband or wife

6. (c) Age of husband, or wife, if alive. year

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

10 15 hr. min.

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

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) May 20/40 (Date received local registrar) (b) Spencer L. Freeman (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town (If outside city or town limits write "RURAL")

(d) Street No. (If rural, give location)

(e) If foreign born, how long in U. S. A. ? years

20. DATE OF DEATH Month Feb day 18 year 1940 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19 that last saw him alive on and that death occurred on the date and hour stated above.

Immediate cause of death

Due to

Due to

Other conditions none (Include pregnancy within 3 months of death)

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 F. B. Farrington (M. D. or other)

Address Hinsville, Mo. Date signed

SUPPLEMENTAL COPY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

MAY 17 1940

S-5749