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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 73

Primary Registration District No. 3006

Registrar's No. 21

1. PLACE OF DEATH:

(a) County BOONE
(b) City or town COLUMBIA
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: BOONE COUNTY HOSPITAL
(If not in hospital or institution, write street number or location) 1
(d) Length of stay: In hospital or institution ENTERED 12-27-39
In this community 3 YEARS
(Specify whether years, months or days)

3. (a) PRINT FULL NAME THOMAS GRIF WILLIAMS 452

3. (b) If veteran, name war NO 3. (c) Social Security No. _____

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife SARAH WALLER WILLIAMS 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased SEPT 5th 1886
(Month) (Day) (Year)

8. AGE: Years 53 Months 4 Days 28 If less than one day _____ hr. _____ min.

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

10. Usual occupation DAIRYMAN

11. Industry or business WOODLAWN DAIRY

12. Name DAVID WILLIAMS

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

14. Maiden name JOSEPHINE HEATHER

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

16. (a) Informant Harry Williams

(b) Address Woodlawn Dairy

17. (a) BURIAL (b) Date thereof FEB. 5, 40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALIFORNIA MO.

18. (a) Signature of funeral director T. O. [Signature]

(b) Address COLUMBIA MISSOURI

19. (a) 2/5/40 (b) Allie Selby
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County BOONE
(c) City or town COLUMBIA
(If outside city or town limits, write "RURAL")
Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A.? LIFE years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month FEB day 3rd
year 1940 hour 12 minute NOON M.

21. I hereby certify that I attended the deceased from Jan. 27th
1940 to Feb. 3, 1940

that I last saw him alive on Feb. 3, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial Pneumonia 3 days
(Bilateral)
2nd & 3rd degree burns 95% of surface

Due to Inhalation of flames
when burned, 1/27-40

Due to _____

Other conditions Acute peritonitis
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy _____

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

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accidental Burns

(b) Date of occurrence Jan. 27, 1940

(c) Where did injury occur? Columbia, Boone Mo.
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Home

While at work? _____ (Specify type of place)

(e) Means of injury Burns

23. Signature James M. Baker (M. D. _____)
Address Columbia, Mo. Date signed 2-4-40

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

151
1/5/13

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 Lyman H. Sprinkle

Licensed Embalmer No. 4013

P. O. Address Columbia, 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 3875

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 73

Primary Registration District No. 3006

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Boone
(b) City or town Columbia
(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) PROVIDER
FULL NAME Thomas Griff Williams

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

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

8. AGE: Years 53 Months 4 Days 28 If less than one day _____ h. _____ 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) _____ (b) Date thereof (Month) (Day) (Year) _____
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (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.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Feb day 3
year 1940 hour _____ minute _____ M.

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

Immediate cause of death Bilateral Pneumonia
2d and 3d degree Burns
of surface Inhalation
of flames when burned
Due to 1-27-1940

(Other conditions acute nephritis
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

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

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) acc. Burner

(b) Date of occurrence 1-27-40

(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?
Home (Tent) did burn.

While a work? _____ (Specify type of place) _____
(e) Means of injury _____

23. Signature James M. Baker _____
(Name of physician or other) _____

Address Columbia Mo _____ Date signed _____

SUPPLEMENTAL

S-5875