

FILED MAY 13 1940

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

14539
Do not use this space.

1. PLACE OF DEATH

(a) County Carroll Registration District No. 135
 (b) Township Carrollton Primary Registration District No. 3010 Registered No. 48
 (c) or City Carrollton (d) Street No. _____ St.
 (e) Length of residence in city or town where death occurred 2 yrs. 0 mos. 0 ds. (If death occurred in Hospital or Institution, write its name instead of street and number)
 (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Norman Williams
 (a) Residence, No. _____ 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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Etta Francis

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 4, 1890

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hr. or min.
49 9 10

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Garage Man
 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) Carrollton Mo.

FATHER 13. NAME Jack Williams

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio

MOTHER 15. MAIDEN NAME Sarah V. Johnson

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ill. Mo.

17. INFORMANT (ADDRESS) Mrs. Norman Williams Carrollton Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Oak Hill Cem. DATE Apr. 16, 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Stanley Carrollton Mo.

20. FILED _____ 19 _____ Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr. 14, 1940

22. I HEREBY CERTIFY, That I attended deceased from 3-25, 1939, to Apr. 14, 1940

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at 12:30 A.M.

The principal cause of death and related causes of importance were as follows:

Pulmonary abscess following pneumonia

Date of onset

April 1939

Other contributory causes of importance:

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ 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) W. G. Newbold, M. D.

130 (Address) Carrollton Mo.

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.

731

601

RECEIVED
District Health Officer No. 8
District File Number 5-10-40
Date Filed

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 Ben W Gibson

Licensed Embalmer No. 2961

P. O. Address Carrollton, 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. 14539

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 135

Primary Registration District No. 3010

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County: Carroll
(b) City or town: Carrollton
(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) PRINT FULL NAME: Norma Williams

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

4. Sex _____ 5. Color or race _____ 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 _____ (Month) (Day) (Year)

8. AGE: Years 49 Months 9 Days 10 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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 _____ (Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) 4-15-1940 (b) Ruth Haskins (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.

20. DATE OF DEATH: Month apr day 14 year 1940 hour _____ minute _____ M.

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

Immediate cause of death _____
Due to _____
Due to _____
Other conditions _____ (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) _____ Means of injury _____

23. Signature W. G. Sturges (M. D. or other) _____
Address Carrollton Mo Date signed _____

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

SUPPLEMENTARY

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 143-39

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 135

Primary Registration District No. 3010

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Carrollton
(b) City or town Carrollton
(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 _____
In this community _____ (Specify whether years, months or days)

3. (a) PRINT FULL NAME Norman 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 m

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 _____ 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) _____ (b) Date thereof _____ (Month) (Day) (Year)

(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 _____ day _____ 14
year _____ hour _____ minute _____ M.

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

Immediate cause of death Pulmonary tuberculosis following pneumonia Duration _____

Due to _____

Due to Lobar Pneumonia

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____ 108

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) _____

(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) _____ (Means of injury)

23. Signature W. G. Sturwood (M. D. or other) _____

Address Carrollton _____ Date signed _____

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

SUPPLEMENTARY