

No. 2
11-10-39
5-17-39
I 22142

State File No. _____

MAY 1 1945
Registration District No. 319

Primary Registration District No. 2001

Registrar's No. 322

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: Springfield Baptist Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 days
(Specify whether)

In this community _____
years, months or days 453

3. (a) PRINT FULL NAME BETTIE ROSE 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 Single

6. (b) Name of husband or wife _____

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

7. Birth date of deceased: October 9 1929
(Month) (Day) (Year)

8. AGE	Years	Months	Days	If less than one day
<u>7</u>	<u>10</u>	<u>5</u>	<u>22</u>	hr. _____ min. _____

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

10. Usual occupation: Student

11. Industry or business: Country School

12. Name: H. H. Williams

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

14. Maiden name: Eula Bennett

15. Birthplace: Barry County Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant: H. H. Williams

(b) Address: Cape Fair MO

17. (a) Buried (b) Date thereof: 4/2/1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Chis Cemetery

18. (a) Signature of funeral director: Kerr Funeral Home

(b) Address: Cassville, Mo. 200

19. (a) 4/2/40 (b) Chas. A. George
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Barry

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

(d) Street No. Route 1
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 1
year 1940 hour 11 minute 45 P. M.

21. I hereby certify that I attended the deceased from 3-30 1940 to 4-1 1940
that I last saw her alive on 4-1 1940
and that death occurred on the date and hour stated above.

Immediate cause of death: Acute Sept
Appendicitis

Due to _____

Due to _____

Due to _____

Other conditions: ✓
(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) _____

(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: E. J. Rogers (M. D. or other) _____

Address: Springfield, Mo. Date signed 4-2-40

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

MOTHER FATHER

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.....

Rufus J. Miller

Licensed Embalmer No. *3794*

P. O. Address *Cassville, 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