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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

15614

State File No. _____

Registration District No. 409 (MAY 15 1940)

Primary Registration District No. 5808

Registrar's No. 63

1. PLACE OF DEATH:

(a) County NEWTON

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

(c) Name of hospital or institution: ROUTE # 3.
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County NEWTON

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

(d) Street No. RURAL # 3
(If rural, give location)

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

3. (a) PRINT FULL NAME CYNTHIA ANN 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 Married

6. (b) Name of husband or wife Jasper Williams

6. (c) Age of husband or wife if alive 83 years

7. Birth date of deceased Oct (Month) 21 (Day) 1856 (Year)

8. AGE: Years	Months	Days	If less than one day
83	6	4	____ hr. ____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

FATHER
12. Name STEVE WILLIAMS
13. Birthplace _____ (City, town, or county) KENTUCKY (State or foreign country)

MOTHER
14. Maiden name SALLIE BACK
15. Birthplace _____ (City, town, or county) KENTUCKY (State or foreign country)

16. (a) Informant's own signature Jasper Williams
(b) Address NEOSHO MISSOURI

17. (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof 4-26-40 (Month) (Day) (Year)
(c) Place: burial or cremation LA CYGNE KANS

18. (a) Signature of funeral director [signature]
(b) Address Neosho Mo

19. (a) 4-26- (Date received local registrar) (b) Onal A Sale, M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 25
year 1940 hour 11 minute 10 P. M.

21. I hereby certify that I attended the deceased from Oct. 31, 1939 to April 25, 1940
that I last saw her alive on April 25, 1940;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Uremia	about 4 da.
Due to: Carcinoma of liver	about 6 mon
Due to:	
Other conditions (Include pregnancy within 3 months of death): None	
Major findings: Of operations: None	
Of autopsy: None	

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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? 5 [illegible] (Specify type of place)
While at work? _____ (e) Means of injury _____

23. Signature Onal A. Sale (M. D. or other)
Address Neosho, Mo. Date signed 4/26

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6,
District File Number 540-1293
Date Filed MAY 13 1940

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 Donald Read, Registered Apprentice No. 202 working under my personal supervision.

Signed [illegible]

Licensed Embalmer No. 3689

P. O. Address Neosho Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.