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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **34596**

**FILED NOV 12 1940**

Registration District No. **1009**

Primary Registration District No. **1002**

Registrar's No. **4442**

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Jackson City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St. Joseph Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution Sept 29 to Oct 25 1940  
In this community Sept 29 to Oct 25 1940  
years, months or days (Specify whether)

8. (a) PRINT FULL NAME ROBERTA BAXTER WILLIAMSON  
ROBERTA BAXTER WILLIAMSON  
8. (b) If veteran, name war \_\_\_\_\_ 8. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife James Lyman Williamson 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased March 30 1877  
(Month) (Day) (Year)

8. AGE: Years 63 Months 9 Days 25 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Housewife

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

12. Name James Baxter  
13. Birthplace Tyrene Co. Ireland (City, town, or county) (State or foreign country)  
14. Maiden name Margaret Creamer Ham  
15. Birthplace Tyrene Co. Ireland (City, town, or county) (State or foreign country)

16. (a) Informant Roberta B. Williamson

(b) Address 4343 Oak

17. (a) Burial (b) Date thereof 10-27-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Woodlawn Cemetery

18. (a) Signature of funeral director W. E. Mitchell

(b) Address 310 N. Main St. Independence

19. (a) Oct. 27, 1940 (b) M. M. Brown  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Independence  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1820 Norton Avenue  
(If rural, give location)  
(e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 25  
year 1940 hour 8 minute 45 A. M.

21. I hereby certify that I attended the deceased from Sept. 26-40  
\_\_\_\_\_ 19\_\_\_\_ to Oct. 25, 19\_\_\_\_  
that I last saw her alive on Oct. 25, 19\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death Cyst. R. Temporal Lobe Brain  
Duration \_\_\_\_\_

Due to encephalitis (7 yrs) 1933

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

Other conditions (Include pregnancy within 3 months of death) 9/13

Major findings: Of operations \_\_\_\_\_

Of autopsy done  
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 1

23. Signature William (M. D. or other) MD

Address 10307 Independence Date signed \_\_\_\_\_

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 me  
....., Registered Apprentice No. ....  
working under my personal supervision.

Signed

Henry D. Mitchell

Licensed Embalmer No. 3925

P. O. Address Indep 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

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. ....

Registration District No. ....

Primary Registration District No. ....

Registrar's No. 4112

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

**1. PLACE OF DEATH:**

(a) County.....

(b) City or town.....  
(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 Roberta B Williamson

3. (b) If veteran, name war.....

3. (c) Social Security No.....

4. Sex Fe

5. Color or race Wh

6. (a) Single, widowed, married, divorced.....

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.....

**MOTHER** { 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 10/27/40

19. (a) (Date received local registrar)..... (b) M. M. Brower (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 10 day 25 year 1946 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 Cerebral meningitis  
secondary to lobes of brain

Due to..... encephalitis

Due to.....

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

Major findings: Of operations.....

Of autopsy Malignant brain  
expt

**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 Dellman (M. D. or other) YMR

Address..... Date signed.....

S-34596