

NOV 21 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 36164

Registration District No. 735

Primary Registration District No. 3034

Registrar's No. 198

1. PLACE OF DEATH:

(a) County Randolph
 (b) City or town Moberly
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Wabash Hospital
(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 William Williamson

3. (b) If veteran, name war _____ 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 _____ 6. (c) Age of husband or wife if _____

7. Birth date of deceased Sept 15th 1862
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
78 - 20 hr. min.

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

10. Usual occupation Retired Switchman

11. Industry or business Wabash R.R.

12. Name no data

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

14. Maiden name no data

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

16. (a) Informant Mrs Ralph Danti

(b) Address Moberly Mo

17. (a) _____ (b) Date thereof Sept 22nd 1940
(Burial, cremation, or other) (Month) (Day) (Year)

(c) Place: burial or cremation Moberly, Mo

18. (a) Signature of funeral director Mahan andson

(b) Address Moberly

19. (a) 9/22/40 (b) Gravel Butler
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 21st
 year 1940 hour 6 minute 30 a.m.

21. I hereby certify that I attended the deceased from September 17, 1940 to September 21, 1940;

that I last saw him alive on September 21, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic PNEUMONIA

Due to Chronic Myocarditis

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? YES

While at work? _____ (e) Means of injury _____

23. Signature P. S. Kuratoki (M. D. or other) _____
 Address Moberly, Mo. Date signed 9/23/40

Duration 4 da.
 Underline the cause to which death should be charged statistically.

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

92C

RECEIVED

District Health Officer No. 10

District File Number 10-40-1971

Date Filed OCT 24 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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed

Frank B. DeWitt

Licensed Embalmer No. 3021

P. O. Address Moberly 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. 36164

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 735-

Primary Registration District No. 3034

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Randolph
(b) City or town Moberly
(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)

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.

3. (a) PRINT FULL NAME William 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 78 Months - Days 20 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)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month 9 day 21 year 1970 hour _____ minute _____ M.

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

Immediate cause of death Hypostatic pneumonia - Bronchial Chr. Myo Carditis

Due to _____

Due to _____

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

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) (e) Means of injury _____

23. Signature P. S. Kwiatkowski (M. D. or other) _____

Address Moberly, Mo. Date signed 12/18/70

SUPPLEMENTARY

MOTHER FATHER

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

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

