

FEB 25 1941

Registration District No. 82 Primary Registration District No. 6085 Registrar's No. _____

1. PLACE OF DEATH
(a) County Shannon Mo.
(b) City or town Terre Haute Mo.
(c) Name of hospital or institution: None
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 75 years years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Shannon Mo.
(c) City or town Terre Haute Mo.
(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.? 0 years.

3. (a) PRINT FULL NAME Mary E. Williams
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

20. DATE OF DEATH: Month Jan 18 day _____ year 1941 hour 6:35 minute _____ a. M.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Chas Williams 6. (c) Age of husband or wife if alive 11 years
7. Birth date of deceased Aug 26 1866 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan 11 1941 to Jan 18 1941; that I last saw her alive on Jan 8 1941; and that death occurred on the date and hour stated above.
Immediate cause of death Influenza

8. AGE: Years 75 74 Months 4 Days 22 If less than one day _____ hr. _____ min.

Duration 7 days
Due to _____
Due to _____

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

Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____

10. Usual occupation House wife

11. Industry or business _____

12. Name Green M. McCallan

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

14. Maiden name Mary McCallan

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

16. (a) Informant Robert Williams

(b) Address Terre Haute Mo.

17. (a) Funeral (Burial, cremation, or removal) (b) Date thereof Jan 19-41 (Month) (Day) (Year)

(c) Place: burial or cremation Phillips Nat

18. (a) Signature of Registrar John H. McCallan

(b) Address Terre Haute Mo.

19. (a) 1-23-41 (Date received local registrar) (b) Frank Hyde MD (Registrar's signature)

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)
(c) Means of injury _____
23. Signature R. D. Davis (M. D. or other) 12
Address Church Tree Mo Date signed 1/18/41

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

RECEIVED

District Health Officer No. 5,

District File Number 241274

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 _____

Licensed Embalmer No. 2516

P. O. Address M. Reed 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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 43-46

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 825-

Primary Registration District No. 6085-

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Shannon
(b) City or town Smiths 1.0
(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 Mary E. Williams

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

4. Sex F 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 Aug 26 1866
(Month) (Day) (Year)

8. AGE: Years 17 1/2 Months 4 Days 22 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 1-15-41 (b) Frank H. DeM...
(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 Jan day 18
year 1941 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 _____

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) (e) Means of injury _____

23. Signature P. J. Davis (M. D. or other) _____

Address Birch Tree Mo Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

