

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

DEC 16 1941

Registration District No. 949

Primary Registration District No. 6225

Registrar's No. 7

1. PLACE OF DEATH:

(a) County Wright
(b) City or town _____
(c) Name of hospital or institution: Rural
(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 Mo (b) County Wright
(c) City or town Tranespring 114
(If outside city or town limits, write "RURAL")
(d) Street No. Rural
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years

3. (a) PRINT FULL NAME Elsie Ellen 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 married

6. (b) Name of husband or wife Mason (c) Age of husband or wife if alive 75 years

7. Birth date of deceased April 11 1972
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
69 7 21 hr. min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name John Williams

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

14. Maiden name Dessie Jackson

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

16. (a) Informant's own signature Flora Frank

(b) Address 2336 SE 5th Demarest Ia.

17. (a) Burial (b) Date thereof Dec 4 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Davis Cem.

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 Dec day 2
year 1941 hour 6 P minute 0 M.

21. I hereby certify that I attended the deceased from Oct 29
1941, to Dec 2 1941

that I last saw her alive on Dec 1 1941
and that death occurred on the date and hour stated above.

Immediate cause of death Apoplexy (Cerebral) Duration _____

Due to _____

Due to _____

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

Major findings: Of operations 830

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 J. H. Hough (M. D. or other) _____

Address Tranespring Date signed _____

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

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.

RECEIVED

District Health Officer No. 6,

District File Number 1241-1856

Date Filed DEC 12 1941

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.....

P. O. Address.....

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.

Registration District No. 949

Primary Registration District No. 6225

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Wright

(b) City or town Rural
(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 _____
(Specify whether _____)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Wright

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

(d) Street No. _____
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Clair C. Williams

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July Day _____
year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

5. Color or race W

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Apr 11 1877
(Month) (Day) (Year)

8. AGE: Years 69 Months 7 Days _____
(If less than one day) _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry of business _____

MOTHER FATHER

12. Name _____

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

14. Maiden name _____ (State or foreign country) _____

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 Rt. 111, Gasconade

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

Duration

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 _____ (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTARY

