

FILED JUN 3 1943

Registration District No. _____

Primary Registration District No. 2000

Registrar's No. 376

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

1. PLACE OF DEATH:

(a) County GREENE

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

(c) Name of hospital or institution:
St. John's Hospital 0
(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)

8. (a) PRINT FULL NAME ANNA MAY WILLIAMSON

8. (b) If veteran, name war NONE

8. (c) Social Security No. NONE

4. Sex FEMALE 5. Color or race WHITE

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

6. (b) Name of husband or wife Unknown

6. (c) Age of husband or wife if alive Dec 29 years (Day) (Year)

7. Birth date of deceased April 29 1865
(Month) (Day) (Year)

8. AGE: Years 78 Months 0 Days 9 If less than one day hr. min.

9. Birthplace Unknown MO. 0
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business at Home

12. Name Thomas Mc Swain

13. Birthplace Lewis Co. MO. 0
(City, town, or county) (State or foreign country)

14. Maiden name Malinda East

15. Birthplace Unknown IND. 1
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Malinda Swain

(b) Address R.F.D. #1 Springfield Mo.

17. (a) (Burial, cremation, or removal) Burial (b) Date thereof May 10 1943
(Month) (Day) (Year)

(c) Place: burial or cremation at home

18. (a) Signature of funeral director J. W. Williams Co.

(b) Address Springfield MO.

19. (a) 510-48 (b) W. S. Handley
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Greene 0

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

(d) Street No. Rural R 1
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5-8-1943 day _____
year _____ hour 7 minute 450 M.

21. I hereby certify that I attended the deceased from July 1 1941 to May 8 1943
that I last saw him alive on May 8 1943
and that death occurred on the date and hour stated above.

Immediate cause of death uraemia

Due to chronic nephritis & chronic myocarditis

Due to arteriosclerosis

Other conditions Senility
(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 Walter Swain (M. D. or other) MD

Address Springfield MO Date signed 5-8-43

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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. 403

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.