

U.S. Form 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **29143**
Registrar's No. **57**

Registration District No. **295**

Primary Registration District No. **4443**

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

1. PLACE OF DEATH:
(a) County **Randolph**
(b) City or town **Huntsville**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
South Main Street
(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 **Randolph**
(c) City or town **Huntsville**
(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 **Amy E. Williams**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **August** day **27**
year **1943** hour **8:30 P.M.** minute _____ M.

4. Sex **Female** 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 alive _____ years
7. Birth date of deceased: **December 18 1868**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **July 5 1943** to **Aug 27 1943**
that I last saw her alive on **Aug 27 1943**
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
74 8 9 hr. min.

Immediate cause of death: **Coronary Thrombosis** Duration **30 min**

9. Birthplace: **Grundy County Missouri**
(City, town, or county) (State or foreign country)

Due to: **Hypertension & Arterio-sclerosis**

10. Usual occupation **Housewife**

Other conditions: (Include pregnancy within 3 months of death) **94**

11. Industry or business _____

Major findings: Of operations **none** Of autopsy **none**

12. Name **Sidney J. Jones**

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

14. Maiden name **Eliza Gee**

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

16. (a) Informant **Mr. Lonnie Jones**

(b) Address **Huntsville, Missouri**

17. (a) **burial** (b) Date thereof **8/29/1943**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Huntsville Cemetery**

18. (a) Signature of funeral director **Tom B. Patton**
(b) Address **Huntsville, Mo.**

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

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 **R. W. Dreyer** (M. D. or other) **MD**
Address **Huntsville, Mo.** Date signed **9/1/43**

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

RECEIVED

District Health Officer No. 10

District File Number 9-43-1510

Date Filed SEP 10 1943

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 Paul J. Patton

Licensed Embalmer No. 4095

P. O. Address Huntsville, Ala

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. left

Registration District No. 290

Primary Registration District No. _____

Registrar's No. _____

1. PLACE OF DEATH: Randolph
 (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 _____ (Specify whether
 years, months or days)

3. (a) PRINT FULL NAME: Amy 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 W
 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 74 Months 8 Days _____ If less than one day _____ 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)
 (Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) 9-1-43 (b) Mrs. P. D. ...
 (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) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 27 year 43 hour _____ minute _____ M.

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

Duration

Due to _____

Due to _____

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

Major findings:
 Of operations _____

Of autopsy _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

29143