No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 22 1944

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 14120

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 58

1. PLACE OF DEATH: (a) County Boone (b) City or town Columbia (If outside city or town limits, write "RURAL" and name of township) (c) Name of hospital or institution: Gatewood Convalescent Home (If not in hospital or institution, write street number or location) (d) Length of stay: In hospital or institution 14 days (Specify whether years, months or days) In this community 14 days

2. USUAL RESIDENCE OF DECEASED: (a) State Missouri (b) County Calloway (c) City or town Guthrie R. F. D. (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 William Williams

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex male

5. Color or race negro

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

6. (b) Name of husband or wife

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

7. Birth date of deceased 8 (Month) 10 (Day) 1871 (Year)

8. AGE: Years 72 Months 6 Days 19 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER 12. Name Frank Williams

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

MOTHER 14. Maiden name Amanda Cason

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

16. (a) Informant Clarence Williams

(b) Address Columbia, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 5 44 (Month) (Day) (Year)

(c) Place: burial or cremation Guthrie R. F. D.

18. (a) Signature of funeral director Stuart Parker

(b) Address Columbia Missouri

19. (a) 3-6-1944 (Date received local registrar) (b) Edna H. Barker (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 29 th year 1944 hour 7:30 minute P.M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on Feb 22 , 1944; and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia Bronchial — Duration 6 day

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations no op

Of autopsy none

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

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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? (Specify type of place)

While at work? (e) Means of injury

23. Signature A W Kaufschmidt (M.D. or other)

Address Columbia Mo Date signed 3-4-44

1250 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number.....
Date Filed 4-30-44

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 Stuart P. Parker

Licensed Embalmer No. 2900

P. O. Address. Columbia Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.