V. S. No. 2
M—11-10-39
Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUL 20 1944

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24094

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 149

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

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:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 10 2 4

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

(d) Street No. 400 Hickman
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME Sallie William

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F. 3

5. Color or race

6. (a) Single, widowed, married, divorced 2

6. (b) Name of husband or wife Curtis Williams

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

7. Birth date of deceased Oct. (Month) 25 (Day) 1873 (Year)

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

9. Birthplace Boone Co. (City, town, or county) Mo 0 (State or foreign country)

10. Usual occupation Housekeeper

11. Industry or business

FATHER
12. Name Charles Smith
13. Birthplace Do not Know (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name Oliva Smith
15. Birthplace Do not Know (City, town, or county) 9 (State or foreign country)

16. (a) Informant Laura Pipes
(b) Address 400 Hickman ave

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6 (Month) 23 (Day) '44 (Year)
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director A. C. Freeman
(b) Address 608 Park Ave

19. (a) 6-23-'44 (Date received local registrar) (b) Edna H. Barlue (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 22-~~23~~
year 1944 hour 10 minute 10 A M.

21. I hereby certify that I attended the deceased from 2-14-, 1944 to 6-22-, 1944
that I last saw her alive on 6-24-, 1944
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Myo Cordilis Do not know	
Due to	
Due to	
Other conditions Arthritis Do not know (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

9321

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) No
(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 W. P. Dyson (M. D. or other) M D
Address Columbia Mo Date signed 6-23-44

1250

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed 7-18-44

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 A. C. Freeman

Licensed Embalmer No. 28-37

P. O. Address Columbia 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, above space should be left blank.