

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 33784
Registrar's No. 1108

FILED NOV 13 1944

Registration District No. 42 Primary Registration District No. 1000

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

1. PLACE OF DEATH
(a) County Buchanan
(b) City or town St. Joseph
(c) Name of hospital or institution 227 E. Pauline Street
(d) Length of stay: In hospital or institution none
In this community About 25 years

3. (a) PRINT FULL NAME Janetta Williams
3. (b) If veteran name war None 3. (c) Social Security No. None

4. Sex Female 5. Color or race negro
6. (a) Single, widowed, married, divorced widow
6. (b) Name of husband or wife deceased (c) Age of husband or wife if alive deceased years
7. Birth date of deceased Unknown

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

9. Birthplace Kansas City MO.

10. Usual occupation House keeper

11. Industry or business None

MOTHER FATHER

12. Name Tom James

13. Birthplace Unknown

14. Maiden name Unknown

15. Birthplace Unknown

16. (a) Informant Gene Bluff

(b) Address 227 E. Pauline

17. (a) Burial (b) Date thereof Sept 20-1944

(c) Place: burial or cremation Ashland Cemetery

18. (a) Signature of funeral director James S. Son

(b) Address 1602 Mission St.

19. (a) (b)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Buchanan
(c) City or town St. Joseph
(d) Street 227 E. Pauline Street
(e) Citizen of foreign country? No.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept. day 26 year 1944 hour 2 minute 45:00 M.
21. I hereby certify that I attended the deceased from May 5 1944 to Sept. 36 1944

that I last saw her alive on Sept 26 1944 and that death occurred on the date and hour stated above.
Immediate cause of death Paralysis ascending

Due to Arteriosclerosis of head
Due to Sclerosis of head

Other conditions (Include pregnancy within 3 months of death) 53

Major findings: Of operations None

Of autopsy None

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?
(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 J. S. Son (M. D. or other)
Address 123 S 50 16th St Date signed 9-27-44

Duration

5 months
4 yrs
some time

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 *A. T. Ramsey*
Licensed Embalmer No. *4081*
P. O. Address *1602 Messanic*

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.

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 1108

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St Joseph
(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 _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Janetta Williams

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race N 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) unk (Day) _____ (Year) _____

8. AGE: Years about 69 Months _____ Days _____ If less than one day _____ min.

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

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) 9/29/44 (b) Valent J. Piakle
(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 Sept Day 26 Year 1944 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 _____

Duration _____

Due to _____

Due to _____

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

PHYSICIAN

Major findings: Of operations _____

Of autopsy _____

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

MOTHER FATHER

33784