

FILED DEC 28 1944

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

41021

State File No.

Registration District No. 87

Primary Registration District No. 5324

Registrar's No.

1. PLACE OF DEATH:

(a) County Crawford
(b) City or town Beaufort, Russell Boone
(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) 1
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 35 years years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Crawford
(c) City or town Beaufort
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? Missouri (Yes or No)
If yes, name country 1

3. (a) PRINT FULL NAME MARY 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 widowed
6. (b) Name of husband or wife John Williams 6. (c) Age of husband or wife if alive 1870 years
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 73 Months - Days - If less than one day hr. min.

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

10. Usual occupation House Wife

11. Industry or business Own House

MOTHER FATHER { 12. Name John Jensen
13. Birthplace Denmark (City, town, or county) (State or foreign country)
14. Maiden name Mary Murphy
15. Birthplace Ireland (City, town, or county) (State or foreign country)

16. (a) Informant John Sanders

(b) Address 4782 Campbell Place St. Louis 8, Mo
17. (c) Date thereof 5-21-43 (Month) (Day) (Year)

(c) Place: burial or cremation St. Peter's Church

18. (a) Signature of funeral director Edgar W. Rapphor

(b) Address Sullivan, Mo

19. (a) 7-19-44 (b) Williams (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 19 year 1943 hour 1 minute _____ M.

21. I hereby certify that I attended the deceased from May 16 1943 to MAY 19 1943 that I last saw him alive on May 16 1943 and that death occurred on the date and hour stated above.

Immediate cause of death myocarditis

Due to _____

Due to 93%

Other conditions (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 H. J. Spurn (M. D. or other) _____
Address Lebanon Date signed 5-20-43

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.....

Edgar W. Laffoon

Licensed Embalmer No. *3394*

P. O. Address *Sullivan Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete 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. *Jan*

Registration District No. *87*

Primary Registration District No. *5324*

Registrar's No. _____

1. PLACE OF DEATH:

(a) County *Crawford*
(b) City or town *Boone Rural*
(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 _____
years, months or days

3. (a) PRINT FULL NAME *Mary 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 Months Days If less than one day _____ min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER { 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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) (Date received local registrar) (b) *C. Williams* (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 *May* 9
year *1945* hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____;

that I last saw him/her alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____ (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 _____ (M. D. or other)

Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

