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5-17-39  
X37823

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

FEB 7 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No.

2801

Registration District No. 193

Primary Registration District No. 5713

Registrar's No.

1. PLACE OF DEATH:

(a) County McDonald  
(b) City or town Rural  
(c) Name of hospital or institution: none  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution. 50 yrs  
In this community 50 yrs  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County McDonald  
(c) City or town Rural  
(d) Street No. Stella, Mo  
(e) Citizen of foreign country? no  
If yes, name country no

3. (a) PRINT FULL NAME LON WILLIAMS

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

4. Sex Male 5. Color or race W 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Jewetta Williams 6. (c) Age of husband or wife if alive 18 1/2 years  
7. Birth date of deceased Aug 11 1873  
(Month) (Day) (Year)

8. AGE: Years 71 Months 5 Days \_\_\_\_\_ If less than one day hr: \_\_\_\_\_ min.

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

10. Usual occupation Farming

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name James Williams  
13. Birthplace Not known  
14. Maiden name Not known  
15. Birthplace Not known

16. (a) Informant James Williams  
(b) Address Stella, Mo  
17. (a) burial (b) Date thereof Jan 13 45  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Union Bur. & Stella

18. (a) Signature of funeral director Wm. Harry Ogden  
(b) Address Wheaton, Mo.

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 11 year 1945 hour 12 minute A.

21. I hereby certify that I attended the deceased from Jan 11 1945 to Jan 11 1945  
that I last saw him alive on Jan 11 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Kolob pneumonia

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? \_\_\_\_\_  
(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. H. Bradford (M. D. or other) \_\_\_\_\_  
Address Stella, Mo. Date signed 2/3/45

PHYSICIAN

Underline the cause to which death should be charged statistically.

1205 (Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED FEB 6 1945

District Health Officer No. ....

District File Number 145-13 .....

Date Filed FEB 6 1945 .....

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 Wm Morris Pope .....

Licensed Embalmer No. 3442 .....

P. O. Address Wheaton, 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, fact should be so stated above.**

Registration District No. 195 Primary Registration District No. 5713

1. PLACE OF DEATH:

(a) County McDonald  
(b) City or town Rural Cydonia Mo  
(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 Len Williams

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

4. Sex m 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 Aug 11  
(Month) (Day) (Year)

8. AGE: Years 71 Months 5 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) Feb 16 - 45 (b) Jana Martus  
(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 \_\_\_\_\_ day \_\_\_\_\_  
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.

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

SUPPLEMENTARY

2801