V. S. No. 2
50M—5-42
Rev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 1 1945

Registration District No. 128

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 2000

State File No. C107

Registrar's No. 109

1. PLACE OF DEATH:

(a) County GREENE

(b) City or town Springfield (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Springfield Baptist Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 days (Specify whether In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State ARKANSAS (b) County Boone

(c) City or town Omaha (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

3. (a) PRINT FULL NAME Harold Williams

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex MALE

5. Color or race White

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

6. (b) Name of husband or wife None

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

7. Birth date of deceased August (Month) 8 (Day) 1941 (Year)

8. AGE: Years 3 Months 5 Days 29 If less than one day hr. min.

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

10. Usual occupation Child

11. Industry or business

FATHER
12. Name Bill Williams Jr.
13. Birthplace OMAHA (City, town, or county) ARK. (State or foreign country)

MOTHER
14. Maiden name Marie Etichson
15. Birthplace OMAHA (City, town, or county) ARK. (State or foreign country)

16. (a) Informant Bill Williams Jr.
(b) Address Omaha Ark.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-9-45 (Month) (Day) (Year)
(c) Place: burial or cremation OMAHA, ARK.

18. (a) Signature of funeral director L. C. Holt
(b) Address Harrison Ark.

19. (a) 2-7-45 (Date received local registrar) (b) Dr W E Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 7 year 1945 hour 2 minute 10 A. M.

21. I hereby certify that I attended the deceased from 2-6, 1945, to 2-7, 1945, that I last saw him alive on 2-6-45, 19..; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Meningitis	2d.
Due to meningo coccus	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

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)

(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 Urban Busick (M. D. or other)

Address Springfield, Mo Date signed 2-7-45

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No.....

P. O. Address.....

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.