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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 17 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 17093

Registration District No. 142 Primary Registration District No. 55-5-7 Registrar's No. 13

1. PLACE OF DEATH:

(a) County: HOWELL

(b) City or town: FANCHON - Sisson Tw (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: SISSON TWP. (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days) In this community: 12 YEARS.

2. USUAL RESIDENCE OF DECEASED:

(a) State: MISSOURI (b) County: HOWELL

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

(d) Street No.: Peace Valley, Mo. Rt. 1 (If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country:

3. (a) PRINT FULL NAME: WILLIAM THOMAS WILLIAMS

3. (b) If veteran, name war: —

3. (c) Social Security No.: —

4. Sex: MALE

5. Color or race: WHITE

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

6. (b) Name of husband or wife: MARY CATHERINE WILLIAMS

6. (c) Age of husband or wife if alive: 81 years

7. Birth date of deceased: APRIL (Month) 27 (Day) 1864 (Year)

8. AGE: Years 80 Months 11 Days 20 If less than one day hr. min.

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

10. Usual occupation: NONE

11. Industry or business:

FATHER 12. Name: WM. WILLIAMS

13. Birthplace: (City, town, or county) Mo. (State or foreign country)

MOTHER 14. Maiden name: MARTHA CAMPBELL

15. Birthplace: (City, town, or county) Mo. (State or foreign country)

16. (a) Informant: MRS. MARY CATHERINE WILLIAMS

(b) Address: PEACE VALLEY, Mo.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof: APR. 18, 1945 (Month) (Day) (Year)

(c) Place: burial or cremation: BENNETT CHAPEL CEM. SISSON TWP. HOWELL CO

18. (a) Signature of funeral director: Hal Thornburgh

(b) Address: WEST PLAINS, Mo.

19. (a) 5/20/45 (Date received local registrar) (b) Ruth Hurst (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month APRIL day 17 year 1945 hour 6 minute A. M.

21. I hereby certify that I attended the deceased from Jan. 15, 1945 to April 17, 1945 that I last saw him alive on Mar. 17, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Myro-Carditis, Chronic	?
Died during sleep	
Due to: Undetermined	
Due to:	
Other conditions: Chronic Gastritis (Include pregnancy within 3 months of death)	

Major findings:
Of operations: Ø
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: H. Thornburgh (M. D. or Coroner) XXXX M. D.

Address: West Plains, Missouri Date signed 4/18/

1105

(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.

Not Embalmed

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.