S. No. 2
M—8-43
. 5-17-39
1 X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28368

FILED SEP 12 1945

Registration District No. 376 Primary Registration District No. 3059 Registrar's No. 133

4
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1. PLACE OF DEATH:
(a) County St Francois
(b) City or town Bonne Terre
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Bonne Terre Hospital
(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 .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St Francois
(c) City or town Bonne Terre
(If outside city or town limits, write "RURAL")
(d) Street No. 1
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME JOSEPH ROBERT 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 Single
6. (b) Name of husband or wife ✓
6. (c) Age of husband or wife if alive ✓ years
7. Birth date of deceased August (Month) 7 (Day) 1945 (Year)

8. AGE: Years 0 Months 0 Days 0 If less than one day 12 hr. ..... min.

9. Birthplace Bonne Terre (City, town, or county) Missouri (State or foreign country)
10. Usual occupation Home
11. Industry or business .....
MOTHER FATHER
12. Name Bert A Williams
13. Birthplace Pomona (City, town, or county) Illinois (State or foreign country)
14. Maiden name Margaret LaClaire
15. Birthplace Flat River (City, town, or county) Missouri (State or foreign country)
16. (a) Informant Bert A Williams
(b) Address Bonne Terre Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-8-45 (Month) (Day) (Year)
(c) Place: burial or cremation B J Cemetery
18. (a) Signature of funeral director Benham Funeral Co
(b) Address 213 Benham Bonne Terre Mo
19. (a) 8/28/45 (Date received local registrar) (b) Esther Rudloff (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 8th year 1945 hour 6 minute A. M.
21. I hereby certify that I attended the deceased from August 7, 1945, to August 8, 1945 that I last saw him alive on ....., 19..... ; and that death occurred on the date and hour stated above.

Immediate cause of death Intracranial hemorrhage
Due to Disproportion head + Mother's pelvis
Due to .....
Other conditions (Include pregnancy within 3 months of death) Prolapse of umbilical cord
Major findings:
Of operations .....
Of autopsy .....

Duration

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 [illegible] (M. D. or other)
Address Bonne Terre Date signed Aug 12 1945

1347 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 4
District File Number 94S-1034
Date Filed 9-10-45

STATEMENT BY LICENSED EMBALMER

No Embalming

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.