S. No. 2
OM—5-43
v. 5-17-39
I X35671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 21 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 37497

Registration District No. 146 Primary Registration District No. 5568 Registrar's No. 296

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Rural Blue L

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

(c) Name of hospital or institution: 10917 E 15th Street

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether

In this community 10 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town ~~Independence~~ Rural

(If outside city or town limits, write "RURAL")

(d) Street No. 10917 E 15th Street

(If rural, give location)

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

If yes, name country .....

3. (a) PRINT FULL NAME EFFIE L.WILLIAMSON

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex Female

5. Color or race white

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

6. (b) Name of husband or wife William W Williamson

6. (c) Age of husband or wife if alive 75 years

7. Birth date of deceased May (Month) 7 (Day) 1881 (Year)

8. AGE: Years 64 Months 5 Days 16 If less than one day ..... hr. ..... min.

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

10. Usual occupation Housewife

11. Industry or business .....

FATHER
12. Name Will Corrivas
13. Birthplace Unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Ann Long
15. Birthplace Robinson Co. (City, town, or county) Tenn (State or foreign country)

16. (a) Informant Wm.W.Williamson

(b) Address 10917 E 15th Street

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-26-45 (Month) (Day) (Year)

(c) Place: burial or cremation Woodlawn Cemetery

18. (a) Signature of funeral director Geo.C.Carson Funeral Home

(b) Address Independence Missouri

19. (a) 10-24-45 (Date received local registrar) (b) James W. Ross (Registrar's signature)

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MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Oct. day 23 year 1945 hour 11 minute 15 A. M.

21. I hereby certify that I attended the deceased from Jan 10 1943 to Oct 23 1945 that I last saw her alive on Oct 23, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Occlusion Duration 10 min

Due to Bronchial Asthma 2 yrs

Due to Essential Hypertension 5 yrs

Other conditions .....
(Include pregnancy within 3 months of death)

Major findings:
Of operations .....
Of autopsy .....

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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 P M Agee D.O. (M. D. or other)

Address Independence Mo Date signed 10-23-45

(License of 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 George E. Larson

Licensed Embalmer No. 2249

P. O. Address Independence 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.