

2-43  
17-39  
X35697

**FILED** APR 10 1946  
Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 342

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

1. PLACE OF DEATH:

(a) County Deerhauan  
(b) City or town St. Joseph  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: General Osteopathic Hosp.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2 mo 9 day  
In this community 1 1/2 yrs. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Deerhauan  
(c) City or town St. Joseph  
(If outside city or town limits, write "RURAL")  
(d) Street No. 711 Water St  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME MABEL-Williamson

3. (b) If veteran, name war no 3. (c) Social Security No. None

4. Sex Female 5. Color or race W.H. 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife Thomas H 6. (c) Age of husband or wife if alive, years \_\_\_\_\_

7. Birth date of deceased March 8 1862  
(Month) (Day) (Year)

8. AGE: Years 84 Months 0 Days 13 If less than one day hr. min.

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

10. Usual occupation at home

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

12. Name James Thompson

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

14. Maiden name Shaw

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

16. (a) Informant Mr. R. W. Thomas

(b) Address St. Joseph

17. (a) no (b) Date thereof Nov. 25-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cameron MO

18. (a) Signature of funeral director Thomas Funeral Home  
(b) Address St. Joseph

19. (a) Mar. 27, 1946 (b) [Signature]  
(Date received local registrar) (Registrar's signature) By R.H.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 23 year 1946 hour 4 PM minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from 1-13-46 to 3-23, 1946  
that I last saw her alive on 3-23, 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to arteriosclerosis

Due to fractured left hip

Other conditions stroke, diabetes  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_  
Of autopsy no

22. If death was due to external causes, the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(c) Did injury occur in or about home, on farm, in industrial place, in public place?

(Specify type of plane) \_\_\_\_\_  
(e) Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other) no  
Address 50 1/2 Francis St Date signed 3-23-46

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

**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.....

*John Roy Stoney*

Licensed Embalmer No.....

*9435*

P. O. Address.....

*St Joseph*

**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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. APRIL  
Registrar's No. 342

Registration District No. 42 Primary Registration District No. 1000

1. PLACE OF DEATH:

(a) County Buchanan  
(b) City or town St Joseph  
(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..... years, months or days)

3. (a) PRINT FULL NAME Mabel Williamson

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive.....

7. Birth date of deceased Mar 8 1894  
(Month) (Day) (Year)

8. AGE: Years 84 Months 0 Days 0 (If less than one day, hr. min.)

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

10. Usual occupation.....

11. Industry or business.....

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) (Date received local registrar) (b) (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 Mar day 13 year 1946 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... to....., 19.....; that I last saw him..... alive on....., 19.....; and that death occurred on the date and hour stated above. Immediate cause of death.....

Duration

Due to.....

Due to.....

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

Major findings: Of operations.....

Of autopsy.....

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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) Fall 131

(b) Date of occurrence Jan 13 1946

(c) Where did injury occur? Home (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home

While at work?..... (Specify type of place) (e) Means of injury Fall

23. Signature E. J. Ferguson (Physician or other)

Address 2015 Maple St Date signed 4-17-46

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

SUPPLEMENTARY

7565

8633