

FILED JUN 7 1946 STANDARD CERTIFICATE OF DEATH

State File No. 16392

Registration District No. 127

Primary Registration District No. 5464

Registrar's No. 127

1. PLACE OF DEATH:

(a) County Greene
 (b) City or town Willard
 (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

Joella Williams3. (b) If veteran,
name war None3. (c) Social Security
No. None4. Sex Female /
5. Color or
race White6. (a) Single, widowed, married,
divorced Widow 26. (b) Name of husband or wife
Henry Williams6. (c) Age of husband or wife if
alive _____ years7. Birth date of deceased June 4, 1860
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
85 11 17 hr. _____ min.9. Birthplace Trimble Co., Ky.
(City, town, or county) (State or foreign country)10. Usual occupation House Wife11. Industry or business At Home12. Name Joe S. Daily /13. Birthplace Unknown /
(City, town, or county) (State or foreign country)14. Maiden name Nancy Wise /15. Birthplace Ky. /
(City, town, or county) (State or foreign country)16. (a) Informant Walter W. Williams(b) Address Springfield Mo.17. (a) Burial (b) Date thereof May 24-1946
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Maple Park Cem.(a) Signature of funeral director J. W. Fligner & Co.
(b) Address Springfield Mo.19. (a) May 23 1946 (b) Jane Appleby
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Greene 39
 (c) City or town Springfield 2
 (If outside city or town limits, write "RURAL")
 (d) Street No. 1431 N. Grant Ave., 6
 (If rural, give location)
 (e) Citizen of foreign country? No. (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 21,
year 1946 hour 2 minute 15 P. M.21. I hereby certify that I attended the deceased from 4-26-46
1946 to May 21, 1946.that I last saw her alive on May 21, 1946.and that death occurred on the date and hour stated above.
Immediate cause of death Pneumonia, lobar Duration 24 hoursDue to Fracture of left hip

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 sta-
tistically.ADDITIONAL
SUPPLEMENTARY
INFORMATION
REQUESTED

22. If death was due to external causes, fill in the following: 133

(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 Lester R. Webb (M. D. or other) _____Address Springfield Date signed 5/22/46

RECEIVED

Greene County Health Office,

County File Number. 46-6-21

Date Filed 6-6-46

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 Ogle Stone, Jr.

Licensed Embalmer No. 4176

P. O. Address Springfield

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.

Registration District No. 127

Primary Registration District No. 5464

1. PLACE OF DEATH:
(a) County Greene
(b) City or town Willard
(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 Jella Williams
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 _____ (Month) (Day) (Year)

8. AGE: Years 85 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace _____ (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) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (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 _____ Year 1946 Hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____ 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 _____

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

(a) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence May 21, 1946

(c) Where did injury occur? Willard Greene Mo. (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home on farm (Specify type of place)
While at work? No (e) Means of injury Fall

23. Signature of _____ Lettie B. Webb (M. D. or other) _____
Date signed 5/10/46

SUPPLEMENTARY

ADDITIONAL
SUPPLEMENTARY
INFORMATION
REQUESTED

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

15279

16392