

No. 2  
5-42  
17-39  
X32873

DEPARTMENT OF COMMERCE  
BUREAU OF CENSUS  
**FILED DEC 19 1946**

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

41294

State File No. ....

Registration District No. 260

Primary Registration District No. 30

Registrar's No. 131

**1. PLACE OF DEATH:**  
 (a) County Macon  
 (b) City or town Macon  
(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 years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Missouri (b) County Macon  
 (c) City or town Macon  
(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.....

**3. (a) PRINT FULL NAME** Preston L. Williams  
 3. (b) If veteran, name war..... 3. (c) Social Security No.....

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month Nov day 23  
 year 1946 hour 12:30 minute P M.  
 I hereby certify that I attended the deceased from July 25 1946 to Nov 23 1946  
 that I last saw him alive on Nov 23 1946  
 and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single  
 6. (b) Name of husband or wife..... 6. (c) Age of husband or wife alive years

Immediate cause of death Coronary occlusion Duration 2 days  
 Due to preceded by fracture of  
vertebrae, pre-gut hernia  
and angina pectoris and hypertension  
 Other conditions (Include pregnancy within 3 months of death) 30 years

**8. AGE:** Years 66 Months 6 Days 19 If less than one day hr. min.

9. Birthplace Macon Mo  
(City, town, or county) (State or foreign country)  
 10. Usual occupation Retired Salesman

Major findings:  
 Of operations.....  
 Of autopsy.....  
**PHYSICIAN**  
 Underline the cause to which death should be charged statistically.

MOTHER FATHER

11. Industry or business Drugs  
 12. Name Lloyd B Williams  
 13. Birthplace Kentucky  
(City, town, or county) (State or foreign country)  
 14. Maiden name Alise Bryan  
 15. Birthplace Kentucky  
(City, town, or county) (State or foreign country)

16. (a) Informant Chas. B. Williams  
 (b) Address Macon Mo  
 17. (a) Burial (b) Date thereof Nov 25-46  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Oakwood Cemetery

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

18. (a) Signature of funeral director Walter Skimber  
 (b) Address Macon Mo  
 19. (a) 12/11/46 (b) W. Ruth McNeely  
(Date received local registrar) (Registrar's signature)

23. Signature W. J. Conway (M. D. or other) 11  
 Address Macon Mo Date signed Nov 25-46

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

185

1 X 438  
M-3-42  
No. 38  
JED

MAR 24 1945

DEC 20 1945

MAR 17 1945

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 *Allert Skinner*

Licensed Embalmer No. *75-1*

P. O. Address *Macon Ga*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl 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. Jan  
Registrar's No. 131

Registration District No. 200

Primary Registration District No. 20X1

1. PLACE OF DEATH:

(a) County Macou  
(b) City or town Macou  
(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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

3. (a) PRINT FULL NAME

Preston L. 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 s

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased May 5  
(Month) (Day) (Year)

8. AGE: 66 Years 6 Months 6 Days (If less than one day, hr. min.)

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

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)

(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 July 23, 1946 year \_\_\_\_\_ 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 \_\_\_\_\_

Due to \_\_\_\_\_

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 statistically.

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

(a) Accident, suicide, or homicide (specify) Fallen Barber Shop

(b) Date of occurrence July 25, 1946

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

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

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury Fallen

23. Signature A.P. Conway MD (M. D. or other)

Address Macou MO Date signed 1-18-47

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—MARK A

MOTHER FATHER

41294