S. No. 2
DM—5-43
v. 5-17-39
o I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 24 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 5478

Registration District No. 7 Primary Registration District No. 3043 Registrar's No. 79

1. PLACE OF DEATH:
(a) County: Marion
(b) City or town: Hannibal (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Lovering 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: Marion 64
(c) City or town: Hannibal (If outside city or town limits, write "RURAL") 3
(d) Street No.: 304½ N. Main st (If rural, give location) 4
(e) Citizen of foreign country? ____ (Yes or No) 0
If yes, name country ____

3. (a) PRINT FULL NAME: Chas. Raymond Williams
3. (b) If veteran, name war ____
3. (c) Social Security No. 492-28-3601
4. Sex: Male 0
5. Color or race: White
6. (a) Single, ~~widowed~~, married, divorced: Single 0
6. (b) Name of husband or wife ____
6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased: Feb (Month) 5 (Day) 1917 (Year)
8. AGE: Years 30 Months ____ Days 6 If less than one day ____ hr. ____ min.
9. Birthplace: Rall. Co (City, town, or county) Missouri (State or foreign country)
10. Usual occupation: Labor
11. Industry or business ____
FATHER 12. Name: Frank William 0
FATHER 13. Birthplace: Rall. Co (City, town, or county) Missouri (State or foreign country)
MOTHER 14. Maiden name: Cora Snell 0
MOTHER 15. Birthplace: Rall. Co (City, town, or county) Missouri (State or foreign country)
16. (a) Informant: Mrs. Cora Moore
(b) Address: Hannibal Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 9-13-47 (Month) (Day) (Year)
(c) Place: burial or cremation: Mt Olivet Cemetery
18. (a) Signature of funeral director: James O'Donnell
(b) Address: Hannibal Mo
19. (a) 2-14-47 (Date received local registrar) (b) Dr E M Lucke (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 6 year 1947 hour 12 minute 55 a.m.
21. I hereby certify that I attended the deceased from 7 Feb 1947, to 11 Feb. 1947; that I last saw him alive on 10 Feb 1947; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Tuberculous Meningitis	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings: Of operations ____
Of autopsy 14

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 0
23. Signature: Merrill J. Pollen (M. D. or other) M.D.
Address: 113½ S. Main Hannibal Mo Date signed 11 Feb/47

189 (Licensed 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.....H. M. O'Donnell.....

Licensed Embalmer No.....3889.....

P. O. Address.....Hannibal 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.