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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED MAR 12 1947  
Registration District No. 294

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 5834  
Registrar's No. 57

Primary Registration District No. 3056

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

1. PLACE OF DEATH:  
(a) County RANDOLPH  
(b) City or town MOBERLY  
(c) Name of hospital or institution:  
WOODLAND HOSP 0  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 10 DAYS  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME MANNIE MAUDE WILLIAMS  
(b) If veteran, name war ✓  
(c) Social Security No. ✓

4. Sex FEMALE 5. Color or race WHITE  
6. (a) Single, widowed, married, divorced MARRIED  
6. (b) Name of husband or wife DAVE WILLIAMS  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased APR. 30 1890  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
56 10 3 hr. min.

9. Birthplace MONROE CO., Mo. 0  
(City, town, or county) (State or foreign country)  
10. Usual occupation AT HOME.

MOTHER FATHER  
11. Industry or business  
12. Name CHARLES W. SHRADER  
13. Birthplace LAWRENCE CO., Mo. 0  
(City, town, or county) (State or foreign country)  
14. Maiden name ORAZINDA MCCANN  
15. Birthplace MONROE CO., Mo. 0  
(City, town, or county) (State or foreign country)

16. (a) Informant DAVE WILLIAMS  
(b) Address RT. 4, CENTRALIA, Mo.  
17. (a) BURIAL (b) Date thereof MAR 5 1947  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation MT. AIRY CEM.  
18. (a) Signature of funeral director Speed & Blakely  
(b) Address PARIS, Mo.  
19. (a) Mch 5-47 (b) Maud Williams  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State MISSOURI (b) County MONROE 69  
(c) City or town RURAL 0  
(If outside city or town limits, write "RURAL")  
(d) Street No. 15 MI. S. OF PARIS 0  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month MARCH day 3<sup>RD</sup>  
year 1947 hour 9 minute 20 A.M.  
21. I hereby certify that I attended the deceased from  
22 Feb. 1947, to 3 Mar 1947  
that I last saw her alive on 3 March 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Carcinoma of Uterus.  
Secondary anemia.  
Due to \_\_\_\_\_

Due to \_\_\_\_\_  
Other conditions 48 B  
(Include pregnancy within 3 months of death)

Major findings: Carcinoma of uterus  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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 \_\_\_\_\_  
23. Signature [Signature] (M. D. or other) no  
Address MOBERLY, Mo. Date signed 5/3/47

Duration  
9 months  
60 days  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

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(Licensed Embalmer's Statement on Reverse Side)

RECEIVED  
Public Health Officer No. 10  
Number 2-47-448  
Date Recd. MAR 1 1947

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.....*E. H. Agnew*.....

Licensed Embalmer No. 4000.....

P. O. Address.....Paris, Missouri......

**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.