

1. PLACE OF DEATH:

(a) County St. Francois
(b) City or town Bismarck, Mo.
(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 20 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Francois
(c) City or town Bismarck
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location) _____
(e) Citizen of foreign country? no (Yes or No) _____
If yes, name country _____

3. (a) PRINT FULL NAME Jackson Williams

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

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Lillie Williams 6. (c) Age of husband or wife if alive 63 years
7. Birth date of deceased Feb 7 1870
(Month) (Day) (Year)

8. AGE: Years 77 Months 1 Days 25 If less than one day hr. _____ min. _____

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

10. Usual occupation retired

11. Industry or business _____

12. Name Doc Williams
13. Birthplace Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Mary Deloney
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Lillie Williams
(b) Address Bismarck Missouri
17. (a) burial (b) Date thereof 4-4-47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Elvins Mo.

18. (a) Signature of funeral director White & Hill
(b) Address White Bismarck Mo.
19. (a) 4-5-47 (b) Esther Rudloff
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 2
year 1947 hour 9 minute 30 P.M.

21. I hereby certify that I attended the deceased from 4-2-47 to 4-2-47 1947
that I last saw him alive on 4-2-47 1947
and that death occurred on the date and hour stated above.

Immediate cause of death arterio sclerosis

Due to _____

Due to Senility

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) _____
(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)
Means of injury _____

23. Signature Gas. W. Luffman (M. D.)
Address Bismarck Mo Date signed 4-8-47

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

RECEIVED

District Health Officer No. 4

District File Number 447-516

Date Filed 4-14-47

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.....

Was not embalmed....., Registered Apprentice No.....
working under my personal supervision.

Signed Rachel White.....

Licensed Embalmer No. 3012.....

P. O. Address Clinton New.....

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.