

FILED MAY 8 1947

Registration District No. 277

Primary Registration District No. 3052

Registrar's No. 164

1. PLACE OF DEATH:

(a) County Pettis
 (b) City or town Sedalia
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Bethwell Hosp. J
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution.....
 (Specify whether
 In this community hisc
 years, months or days)

3. (a) PRINT FULL NAME ARINA KATHRYN WILLIAMS3. (b) If veteran, name war NONE 3. (c) Social Security No. YES UNKNOWN4. Sex FEMALE 5. Color or race W 6. (a) Single, widowed, married, divorced MARRIED6. (b) Name of husband or wife EARL S. WILLIAMS 6. (c) Age of husband or wife if alive 57 years7. Birth date of deceased. AUGUST 17 1900
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
46 8 12 hr. min.9. Birthplace Benton County Mo J
(City, town, or county) (State or foreign country)10. Usual occupation House wife11. Industry or business Home12. Name William H. Humpe J13. Birthplace Benton County Mo J
(City, town, or county) (State or foreign country)14. Maiden name Hanna Eck Host15. Birthplace Benton County Mo J
(City, town, or county) (State or foreign country)16. (a) Informant Earl Williams(b) Address Lincoln Mo.17. (a) Burial (b) Date thereof 5/2/47
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Lincoln Cemetery18. (a) Signature of funeral director Reser Funeral Home(b) Address Lincoln, Mo.19. (a) 5-2-47 (b) Betty Yeager
(Date received local registrar) (Licenses embalmers' signature)

(Licensed Embalmer's Statement on Reverse Side)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Benton J
 (c) City or town Lincoln
 (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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 30
year 1947 hour 12 minute 30 A M.21. I hereby certify that I attended the deceased from 4-10
..... 1946, to 4-29..... 1947,that I last saw her alive on 4-29..... 1947,

and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive Pneumonia Duration 3 daysDue to Being affected i carcinoma in advanced stage

Due to

Other conditions Rectal Vaginal Fistula
(Include pregnancy within 3 months of death)
acute Cervicometra Neoplasia

Major findings:

Of operations.....

Of autopsy.....

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

(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? Yes (Specify type of place) (Specify type of means of injury)23. Signature Betty Yeager (M. D. or other)Address Sedalia, Mo. Date signed 5-2-47

MOTHER FATHER

PHYSICIAN

Underline the cause to which death is attributed.

If death was due to external causes, the physician should be charged with the duty of reporting the same to the coroner.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

RECEIVED

District Health Officer

District File Number 5-7-42

Date Filed 5-7-42

AUG 1 1942

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 John F. Reew
Licensed Embalmer No. 4098
P. O. Address Warsaw

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

State File No. May
Registrar's No. 1678

Registration District No. 274

Primary Registration District No. 3052

1. PLACE OF DEATH:

(a) County Pettis
(b) City or town Sedalia
(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 Alvinia K 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 m

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Aug 17 (Month) (Day) (Year)

8. AGE: Years 46 Months _____ Days _____ (If less than one day) _____ yr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (Date received local registrar) (b) _____ (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 April 30
year 1944 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 Primary Site of Cancer was Cervix Uteri.
Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy 48A

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 Frank B. Long (M. D. or other) _____
Address Sedalia MO. Date signed 5/30/44

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

14504