

S. No. 2
M-8-43
5-17-39
X37823

Registration District No. **FILED APR 23 1947**

Primary Registration District No. **6282**

Registrar's No. **9**

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

1. PLACE OF DEATH:

(a) County **WRIGHT**

(b) City or town **MACOMB**
(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 _____ years, months or days

3. (a) PRINT FULL NAME **Sydney Williams**

3. (b) If veteran, name war **NONE**

3. (c) Social Security No. **NONE**

4. Sex **MALE** 5. Color or race **WHITE**

6. (a) Single, widowed, married, divorced **MARRIED**

6. (b) Name of husband or wife **Cordie Williams**

6. (c) Age of husband or wife if alive **68** years

7. Birth date of deceased **Nov. 17 1874**
(Month) (Day) (Year)

8. AGE: Years **72** Months **4** Days **22** If less than one day _____ hr. _____ min.

9. Birthplace **SNPPD VILL TENN. /**
(City, town, or county) (State or foreign country)

10. Usual occupation **MPYCHANT**

11. Industry or business **GEN. STORE**

12. Name **SAMPSON WILLIAMS**

13. Birthplace **NOT KNOWN**
(City, town, or county) (State or foreign country)

14. Maiden name **ARTANA BYRUPP**

15. Birthplace **SNPPD VILL TENN. /**
(City, town, or county) (State or foreign country)

16. (a) Informant **Cordie Williams**

(b) Address **MACOMB MO.**

17. (a) **BURIAL** (b) Date thereof **APR 13-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **MANFIELD CEMETERY**

18. (a) Signature of funeral director **J.A. Steffe**

(b) Address **MANFIELD MO.**

19. (a) **4-14-47** (b) **Mrs. A. R. Worsheim**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **WRIGHT 114**

(c) City or town **MACOMB**
(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 **APRIL** day **9**
year **1947** hour **3** minute **45 P.M.**

21. I hereby certify that I attended the deceased from _____, 19____, 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 **Coronary Thrombosis** Duration **Instantly**

Patent was dead when I arrived.

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: **94A**

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) _____

(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 _____

23. Signature **J.A. Fyson** (M. D. or other) _____

Address **Manfield Mo** Date signed **Apr 11-47**

347 by Mrs. R. Worsheim (Place of Registrar's Statement on Reverse Side)

RECEIVED

District Health Officer No. 6;

District File Number 447-491

Date Filed APR 22 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 G.A. Steffe
Licensed Embalmer No. 3221
P. O. Address Mansfield 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.