

No. 2
-12-45
5-17-39
I X47070

FILED JUL 11 1947
Registration District No. **28**

Primary Registration District No. **2000**

1. PLACE OF DEATH:

(a) County Greene

(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
403 Boonville Avenue
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community Seven years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene **39**

(c) City or town Springfield **2**
(If outside city or town limits, write "RURAL")

(d) Street No. 403 Boonville Avenue **6**
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) **0**
If yes, name country _____

3. (a) PRINT FULL NAME ALPHA FRANCES WILLIAMS

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female / 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife James A. Williams

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

7. Birth date of deceased: April 28, 1905
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 19,
year 1947 hour 7: minute 50 A. M.

21. I hereby certify that I attended the deceased from June 14 1947 to June 19 1947
that I last saw h. or alive on June 19 1947
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

<u>42</u>	<u>1</u>	<u>21</u>	hr. _____ min. _____
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Immediate cause of death Carcinoma involving uterus, bladder and colon **2 yrs**

Due to undetermined

9. Birthplace Belle Plain, Iowa
(City, town, or county) (State or foreign country)

Other conditions none
(Include pregnancy within 3 months of death)

10. Usual occupation Housewife

Major findings: Of operations none **H-8 B**

MOTHER FATHER

11. Industry or business Home

12. Name Charles F. Wright

13. Birthplace Adell, Iowa
(City, town, or county) (State or foreign country)

14. Maiden name Grace Louise Smith

15. Birthplace Unknown **9**
(City, town, or county) (State or foreign country)

Of autopsy ✓

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

16. (a) Informant James A. Williams (husband)

(b) Address 1635 West High Street

17. (a) Burial (b) Date thereof 6/21/1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(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? ✓

(c) Place: burial or cremation Green Lawn Cemetery

18. (a) Signature of funeral director Alma Lohmeyer Funeral Home
Springfield, Missouri

(b) Address _____

19. (a) 6-21-47 (b) W. E. Hussey MD
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature Wm. H. Selsky (M. D. or other) **M.S.**
Address Springfield, Mo. Date signed 6/21/47

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

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.....

Juvel E. Mandle

Licensed Embalmer No. *2831*

P. O. Address.....

Springfield, 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.