

Registration District No. **68**

Primary Registration District No. **4119**

Registrar's No. **20**

1. PLACE OF DEATH:

(a) County **Christian**  
(b) City or town **Osark**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**County Farm**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **4 days**  
(Specify whether  
In this community **28 years**  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Christian**  
(c) City or town **Chadwick**  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME **Andrew Newton Williams**

8. (b) If veteran, name war \_\_\_\_\_ 8. (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 **Lucinda Williams** 6. (c) Age of husband or wife if alive **72** years  
7. Birth date of deceased **December 9, 1897**  
(Month) (Day) (Year)

8. AGE: Years **75** Months **5** Days **22** If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace **Marshfield Mo**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business **F**

MOTHER FATHER { 12. Name **Milton William S**  
13. Birthplace **Don't know** 9  
(City, town, or county) (State or foreign country)  
14. Maiden name **Sarah Jane Daby**  
15. Birthplace **N. Carolina**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. A.N. Williams**  
(b) Address **Chadwick, Mo**

17. (a) **Burial** (b) Date thereof **6-4-47**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Chadwick, Mo**

18. (a) Signature of funeral director **John Harris**  
(b) Address **Chadwick, Mo**

19. (a) **June 30, 1947** (b) **Louella Leonard**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **10** 19**47**  
year **1947** hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from **May 28** 19**47**, to **June 10** 19**47**; that I last saw him alive on **May 28** 19**47** and that death occurred on the date and hour stated above.

Immediate cause of death **Voluntary Heart Failure**  
Due to **Hypertension - Distended**

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

Major findings: Of operations **9/5/47**  
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 **J. H. Wade** (M. D. or other) \_\_\_\_\_  
Address **Osark Mo** Date signed **6-4-47**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED  
District Health Officer No. 6,  
District File Number 847-936  
Date Filed AUG 24 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 T. B. Chaffin

Licensed Embalmer No. 2192

P. O. Address Orank, 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, above space should be left blank.