S. No. 2
M—1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED SEP 15 1947

Registration District No. 327

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 6076

State File No. 30011

Registrar's No. 1909

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

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Manchester
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Manchester Nursing Home 4
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 days (Specify whether
In this community 3 days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Illinois (b) County Randolph 999
(c) City or town Tilden 11
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No) 2
If yes, name country

3. (a) PRINT FULL NAME BETTY JOAN WILLIAMSON
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 S 0
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased August 30, 1938 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	9	0	5	hr. min.

9. Birthplace St. Louis, Missouri 6
(City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER
12. Name Wade Williamson
13. Birthplace Texas
(City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Juanita Ivy
15. Birthplace Arkansas
(City, town, or county) (State or foreign country)
16. (a) Informant Wade Williamson
(b) Address St. Nicholas Hotel. Springfield Illinois
17. (a) burial (Burial, cremation, or removal) (b) Date thereof 9-8-47 (Month) (Day) (Year)
(c) Place: burial or cremation New St. Marcus Cemetery
18. (a) Signature of funeral director A.W. McLaughlin
(b) Address 2301 Lafayette Avenue
19. (a) 9-9-47 (Date received local registrar) (b) Cecil Sharp MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 5th year 1947 hour 5:25 minute P M.
21. I hereby certify that I attended the deceased from Sept 3, 1947, to Sept 5, 1947 that I last saw her alive on Sept 5, 1947 and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Hemorrhage, Tuberculosis, + Malnutrition

Due to

Due to 13 b

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

Duration

PHYSICIAN

Underline the cause of 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 0
Signature A. L. Merblin (M. D. or other)
Address 3507 Potomac Date signed 9-6-47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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.....C W Cooper.....

Licensed Embalmer No.....3830.....

P. O. Address.....2301 Lafayette Av

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.