V. S. No. 2
50M—1/47
Rev. 5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED NOV 21 1947

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 38780

Registration District No. 170 — Primary Registration District No. 3033 — Registrar's No.

1. PLACE OF DEATH:
(a) County Laclede
(b) City or town Lebanon (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Wallace Memorial (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 days (Specify whether years, months or days) In this community 7 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Laclede
(c) City or town Morgan (If outside city or town limits, write "RURAL")
(d) Street No. No st. Number (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Amanda Jane 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 Married
6. (b) Name of husband or wife John A. Williams
6. (c) Age of husband or wife if alive 74 years
7. Birth date of deceased Dec. (Month) 23 (Day) 1878 (Year)

8. AGE: Years 68 Months 10 Days 9 If less than one day hr. min.

9. Birthplace Kentucky (City, town, or county) (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
MOTHER FATHER
12. Name Belfield Brown
13. Birthplace Wayne Co. Ky. (City, town, or county) (State or foreign country)
14. Maiden name Sarah Sullivan
15. Birthplace Russell Co. Ky. (City, town, or county) (State or foreign country)
16. (a) Informant John A. Williams
(b) Address Morgan Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-4-47 (Month) (Day) (Year)
(c) Place: burial or cremation Roper Cemetery
18. (a) Signature of funeral director W. E. Holman
(b) Address Lebanon, Mo.
19. (a) Nov. 15, 1947 (Date received local registrar) (b) Ora Frankenberger (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 2 year 1947 hour 11 minute 45 A.M.

21. I hereby certify that I attended the deceased from 8-9-1946, to 11-2-47, 19..., that I last saw her alive on 11-2-47, 19..., and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Diabetes Mellitus	(7)
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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

23. Signature R. E. Harell (M. D. or other) M.D.
Address Lebanon Mo. Date signed 11-4-47

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

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

Received 11/19/47

Laclede County Health Unit

File No. 11-47-196

Date Filed 11/19/47

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 Dorsey M. Howe

Licensed Embalmer No. 4222

P. O. Address Lebanon, 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.