

No. 2
-1/47
1-17-39

FEDERAL SECURITY AGENCY

National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 12359

Registrar's No. 728

FILED JAN 5 1947
Registration District No. 521848

Primary Registration District No. 3043

1. PLACE OF DEATH:

(a) County: Marion

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

(c) Name of hospital or institution: U. S. Leman St 1
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Marion 64

(c) City or town: Hannibal 3
(If outside city or town limits, write "RURAL")

(d) Street No.: U. S. Leman St 1 4
(If rural, give location) 10

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country: _____

3. (a) PRINT FULL NAME: Kate Williams

3. (b) If veteran, name war: _____

3. (c) Social Security No.: _____

4. Sex: Female 3
5. Color or race: Black

6. (a) Single, widowed, married, divorced: Widowed

6. (b) Name of husband or wife: Unknown

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

7. Birth date of deceased: July 4 1872
(Month) (Day) (Year)

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

75 5 20 hr. min.

9. Birthplace: _____ (City, town, or county) (State or foreign country)

10. Usual occupation: Housekeeper 12

11. Industry or business: _____

12. Name: Jamie Robinson

13. Birthplace: Alabama
(City, town, or county) (State or foreign country)

14. Maiden name: America Robinson

15. Birthplace: Alabama
(City, town, or county) (State or foreign country)

16. (a) Informant: Mrs Genevieve McKinney

(b) Address: Brooklyn, N. Y.

17. (a) Burial, cremation, or removal: Burial

(b) Date thereof: 12/29/47
(Month) (Day) (Year)

(c) Place: burial or cremation: Robinson Cemetery

18. (a) Signature of funeral director: James Donnell

(b) Address: Hannibal, Mo

19. (a) 12-30-47 (Date received local registrar)

(b) Dr E. M. Luque (Registrar's signature) 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Dec day: 24
year: 1947 hour: 4 minute: 30 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: Semility

Due to: Found dead in Bed.

Due to: _____

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

Major findings: _____

Of operations: _____

Of autopsies: _____

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: _____

23. Signature: James Donnell Grover (M.D. or other)

Address: Hannibal, Mo Date signed: _____

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

MOTHER FATHER

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..... *J. M. O'Donnell*

Licensed Embalmer No. *3229*

P. O. Address *Hannibal, 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.

Registration District No. *209*

Primary Registration District No. *3043*

Registrar's No. *425*

1. PLACE OF DEATH:

(a) County *Marion*

(b) City or town *Hannibal*
(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
years, months or days)

In this community _____ (Specify whether
years, months or days)

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

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex *F*

5. Color or race *B*

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased *July*
(Month) (Day) (Year)

8. AGE: Years *75* Months _____ Days _____ If less than one day
hr. _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country)

10. Usual occupation *clerk housekeeper*

11. Industry or business _____

MOTHER FATHER { 12. Name _____

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

14. Maiden name _____

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____ (If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ day _____
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 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 _____

Duration

Due to _____

Due to _____

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

PHYSICIAN

Major findings:
Of operations _____

Of autopsy _____

Underline the cause to which death should be charged statistically.

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

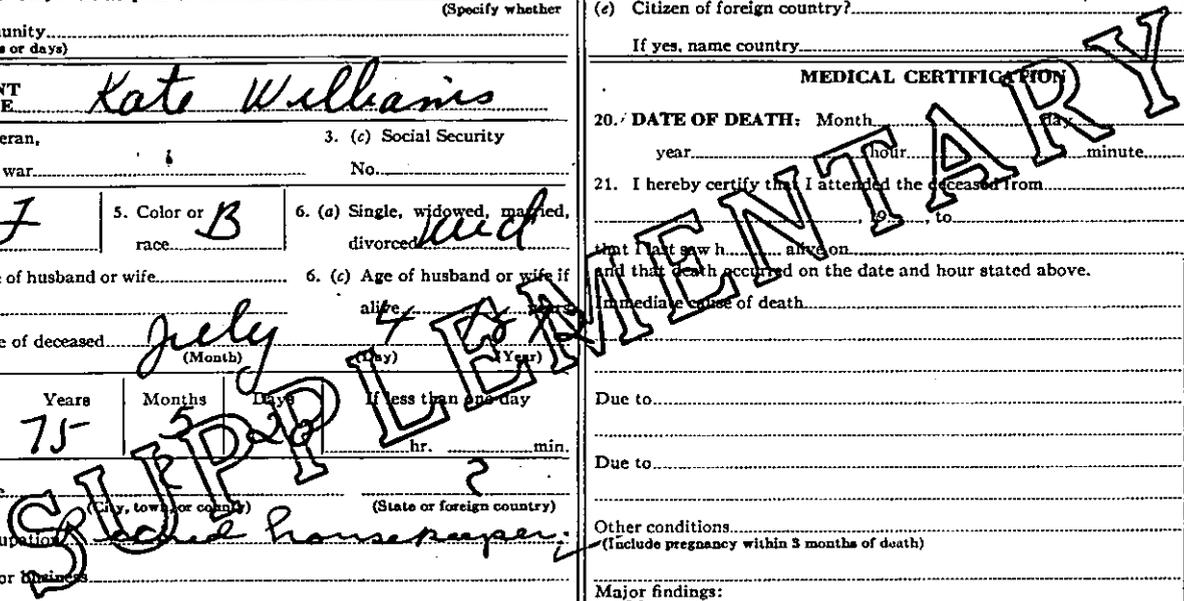
(a) Accident, suicide, or homicide (specify) _____

(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?
While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other)
Date signed _____



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

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