

FILED JUL 26 1948

Registration District No. **299**

Primary Registration District No. **4563**

Registrar's No. **18**

1. PLACE OF DEATH:

(a) County Reynolds
(b) City or town Bunker
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 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

3. (a) PRINT FULL NAME Thelma Ray Williams

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 1. Color or race White 6. (a) Single, widowed, married, divorced 0

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

7. Birth date of deceased March 21 1948
(Month) (Day) (Year)

8. AGE: Years 3 Months 4 Days 6 If less than one day 5 hr. 20 min.

9. Birthplace St. Louis MO
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name Floyd Williams
13. Birthplace Shannon MO
(City, town, or county) (State or foreign country)
14. Maiden name Wanda Craft
15. Birthplace Emmerson MO
(City, town, or county) (State or foreign country)

16. (a) Informant Floyd Williams
(b) Address Bunker MO
17. (a) Burial (b) Date thereof 5/22/48
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation W. Harris

18. (a) Signature of funeral director Frank Patrick
(b) Address Bunker MO
19. (a) 7/17/48 (b) G. M. Patrick
(Data received from registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Reynolds
(c) City or town Bunker
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 21
year 1948 hour 5 a.m. minute 20 M.

21. I hereby certify that I attended the deceased from March 18, 1948 to March 20, 1948
that I last saw her alive on March 18, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia fever

Due to _____
Due to _____

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

Major findings:
Of operations _____
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 0

23. Signature L. P. Brown (M. D. or other) MO
Address Bunker, Mo. Date signed 7/17/48

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

MOTHER FATHER

ADDITIONAL INFORMATION

PHYSICIAN Underline the cause to which death should be charged statistically.

Dr. C. M. Fitzpatrick
Lester ville mo

RECEIVED

7-19-48

District Health Officer No. 8,

District File Number. 248471

Date Filed 7-19-48

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.....

Licensed Embalmer No.

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

Registration District No. 299 Primary Registration District No. 4563

1. PLACE OF DEATH:
(a) County Reynolds
(b) City or town Burner
(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 _____)

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

3. (a) PRINT FULL NAME Thelma R. 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 5

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

7. Birth date of deceased March 2 (Month) (Day) (Year)

8. AGE: Years 3 Months _____ Days _____ If less than one year _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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 March 1948 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: Lobar pneumonia Duration _____

Due to _____

Due to _____

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

Major findings: Of operations _____

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) (c) Means of injury _____

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

Address _____ Date signed _____

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PHYSICIAN
Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

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

B
45
33880

5-23940