

1939 AUG 11 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

26602
Do not use this space.

1. PLACE OF DEATH

(a) County Pulaski Registration District No. 717
(b) Township Medicine Primary Registration District No. 5946 Registered No. _____
(c) City _____ (d) Street No. _____
(If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 459 S. 2nd St. Indian County, Mo. St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Zachariah Williams

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 14 1840

7. AGE YEARS 89 MONTHS 7 DAYS 6 If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housekeeper
9. Industry or business in which work was done, as saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Frankfort Mo
Indiana

FATHER 13. NAME Henry Green

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

MOTHER 15. MAIDEN NAME Amy Adams

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New York

17. INFORMANT (ADDRESS) Chas. Foster
Lucerne Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Rushy DATE July 23 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Martin Funeral Home
Pulaski Mo

20. FILED July 21 1939 Studabaker
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 20 1939

22. I HEREBY CERTIFY, that I attended deceased from July 19 1939 to July 20 1939
I last saw her alive on July 19 1939 Death is said to have occurred on the date stated above, at 2.2 m.
The principal cause of death and related causes of importance were as follows:

Phlebotomy
Date of onset _____
Other contributory causes of importance: Heart Attack

Name of operation _____ Date of _____
What test confirmed diagnosis? X Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19 _____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify _____
(Signed) J. A. Steele, M. D.
(Address) Lucerne Mo

562

RECEIVED

District Health Officer No. 10

District File Number 8-39-1369

Date Filed AUG 4 1939

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 H. Ivan Martin

Licensed Embalmer No. 3760

P. O. Address Princeton 7

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

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

26602
Do not use this space.

1. PLACE OF DEATH
 (a) County Guthrie Registration District No. 717
 (b) Township Medicine Primary Registration District No. 3946 Registered No. _____
 (c) City _____ (d) Street No. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Lydia Caroline Williams
 (a) Residence, No. _____ St.
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) _____

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
89 7 6

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

FATHER
 13. NAME _____
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

MOTHER
 15. MAIDEN NAME _____
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL
 PLACE _____ DATE _____ 19.

19. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED _____ 19 _____
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-20, 1939

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____ to _____, 19____
 I last saw him alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.
 The principal cause of death and related causes of importance were as follows:
Rheumatism
Heart attack
Myocarditis
and age
 Date of onset _____

Other contributory causes of importance:
None

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) G. A. Steele, M. D.
 (Address) Lubersne 200

SUPPLEMENT

5-26602

1939