

REC'D AUG 11 1939

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

27068
Do not use this space.

1. PLACE OF DEATH

(a) County TEXAS² Registration District No. 19
(b) Township MORRIS¹ Primary Registration District No. 6139 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 JOHN C. WILLIAMS

(a) Residence, No. _____ 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) married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 31, 1870

YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>69</u>	<u>2</u>	<u>7</u>	

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
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) Wright County (STATE OR COUNTRY) Mo.

13. NAME John C. Williams

14. BIRTHPLACE (CITY OR TOWN) Tenniss (STATE OR COUNTRY) Mo.

15. MAIDEN NAME Mary S. Brown

16. BIRTHPLACE (CITY OR TOWN) Mo. (STATE OR COUNTRY) _____

17. INFORMANT Cora Elizabeth Williams (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL PLACE Fowler Cemetery DATE June 9 1939

19. FUNERAL DIRECTOR (NAME) Funeral Home (ADDRESS) mt. Grove, Mo.

20. FILED _____, 19 _____ Local Registrar 777

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 8 1939

22. I HEREBY CERTIFY, That I attended deceased from 6/7 - 1939, to 6/8 - 1939. I last saw him alive on 6/7 - 1939. Death is said to have occurred on the date stated above, at 10 A.M.

The principal cause of death and related causes of importance were as follows:
Hodgkin's Disease Date of onset _____

Other contributory causes of importance: 77b

Name of operation _____ Date of _____
What test confirmed diagnosis clinical 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) R. A. Ryan, M. D.

(Address) mt. Grove, Mo.

A. B.—Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is required.

RECEIVED

District Health Officer No. 6,

District File Number 839-1565

Date Filed AUG 9 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, Russell Barber

or by _____

Registered Apprentice No. _____, working under my personal supervision.

Signed Russell Barber

Licensed Embalmer No. 3848

P. O. Address Mt. Grove, 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, 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

27068
Do not use this space.

1. PLACE OF DEATH

(a) County Texas Registration District No. 18
(b) Township Morris Primary Registration District No. 6139 Registered No. 16
(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

John C. Williams
(a) Residence, No. _____ 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

MEDICAL CERTIFICATE OF DEATH

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Cora Elizabeth Williams

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar 31 1870

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
69 2 7

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
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) Wright Co. Tenn

FATHER 13. NAME Henry Eli Williams

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

MOTHER 15. MAIDEN NAME Mary S. Brown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

17. INFORMANT (ADDRESS) Cora Elizabeth Williams

18. BURIAL, CREMATION, OR REMOVAL PLACE Fowler Cem DATE 6-9-1939

19. FUNERAL DIRECTOR (ADDRESS) Russell Dasher
Mt Grove Mo.

20. FILED Sept 19 1939 Pearl E. McCall
(Local Registrar)

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-8-1939

22. I HEREBY CERTIFY, That I attended deceased from 6-7-1939 to 6-8-1939
I last saw him alive on 6-7-1939 Death is said to have occurred on the date stated above, at 10 A. m.
The principal cause of death and related causes of importance were as follows:

1. Hodgkins Disease Date of onset

Other contributory causes of importance:

Name of operation..... Date of.....
What test confirmed diagnosis? Clinical 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) R. A. Ryan, M. D.
(Address) Mt Grove Mo

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is required. Exact statement of OCCUPATION is required. Exact statement of OCCUPATION is required.

