N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REC'D SEP 19 1939

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

29661
Do not use this space.

1. PLACE OF DEATH
(a) County Maries
Registration District No. 546
(b) Township Johnson
Primary Registration District No. 5735
Registered No.
(c) or City
(d) Street No. St.
(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.

452
2. PRINT FULL NAME Lydia C. Williams
(a) Residence, No. Vichy Mo 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 John Williams
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 2-13-1863
7. AGE YEARS 76 MONTHS 5 DAYS 27 If LESS than 1 day, ... hrs. or ... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. House wife
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) July 1-39
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) Vichy
(STATE OR COUNTRY) Mo

FATHER
13. NAME Jacob Moreland
14. BIRTHPLACE (CITY OR TOWN) Maries Co
(STATE OR COUNTRY) Mo

MOTHER
15. MAIDEN NAME Susana Eckart
16. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY) Ind.

17. INFORMANT Mrs Frank Southard
(ADDRESS) Vichy Mo

18. BURIAL, CREMATION, OR REMOVAL
PLACE Walker DATE Aug 12 1939

19. FUNERAL DIRECTOR (NAME) W. E. Lichlider
(ADDRESS) St James Mo

20. FILED Aug 11- 1939 Sam A. Warner
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-10- 1939

22. I HEREBY CERTIFY, That I attended deceased from July 7 1939, to Aug 10 1939
I last saw her alive on Aug 10 1939 Death is said to have occurred on the date stated above, at 11 a.m.
The principal cause of death and related causes of importance were as follows: Date of onset
Cholangitis
Suppurative

Other contributory causes of importance:

Name of operation none 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? no 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) A. J. Jones , M. D.
(Address) Vichy Mo

(Licensed Embalmer's Statement on Reverse Side)

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 com with the above constitutes grounds for revocation of license.)

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