

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

31995
Do not use this space.

1. PLACE OF DEATH *Caldwell* Registration District No. *94*
 (a) County *Caldwell* (b) Township *Breckwidge* Primary Registration District No. *4055*
 (c) City *Breckwidge* (d) Street No. *38* Registered No. _____ St. _____
 (e) Length of residence in city or town where death occurred *88* yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME *Caroline Williamson*
 (a) Residence, No. *Breckwidge Tenn* St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *widow*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Oct 1 1850*

7. AGE YEARS *88* MONTHS *11* DAYS *8* If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *House*

9. Industry or business in which work was done, as saw mill, bank, etc. *Keeper*

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) *Gould Farm Mo*

FATHER 13. NAME *James Bettery* 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Gould Farm Mo*

MOTHER 15. MAIDEN NAME *Don't Know* 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Don't Know*

17. INFORMANT (ADDRESS) *L. H. Williamson Breckwidge Mo*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Radical Cemetery Sept 10 1939*

19. FUNERAL DIRECTOR (NAME) (ADDRESS) *J. F. McCall Son Breckwidge Mo*

20. FILED *Sept 10 1939 A. P. Wilbey* Local Registrar.

MEDICAL CERTIFICATE OF DEATH

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

22. I HEREBY CERTIFY, That I attended deceased from *Jan 1930* to *Sept 8 1939*
 I last saw her alive on *Sept 8 1939* Death is said to have occurred on the date stated above, at *5 P.*
 The principal cause of death and related causes of importance were as follows:
Chronic Bronchitis
Impending age

Other contributory causes of importance: _____

Name of operation *None* Date of _____
 What test confirmed diagnosis? *Chinidial* Was there an autopsy? *No*

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? Date of injury *1939*
 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 *None*
 Nature of injury *None*

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

(Licensed Embalmer's Statement on Reverse Side)

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

V. S. NO. 2. 50M-9-19-38 I X16025

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.

RECEIVED

District Health Officer No. 11,

District File Number 1039-1278

Date Filed OCT 11 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.....

T. McBeek

....., Registered Apprentice No.

working under my personal supervision.

Signed *T. McBeek*

Licensed Embalmer No. 1570

P. O. Address Brockwidge 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.