

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

35457

State File No. _____

Registration District No. 69

Primary Registration District No. 5-11.5

Registrar's No. 5

1. PLACE OF DEATH:

(a) County Ballinger
(b) City or town Ballinger
(c) Name of hospital or institution: no
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 years (Specify whether years, months or days)
In this community 2 years

3. (a) PRINT FULL NAME Auth Williams 452

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

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

7. Birth date of deceased Feb 17 1907
(Month) (Day) (Year)

8. AGE: Years 32 Months 7 Days 3 If less than one day hr. _____ min. _____

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

10. Usual occupation House Keeping

11. Industry or business _____

12. Name Sally Oliver

13. Birthplace Kennett Mo
(City, town, or county) (State or foreign country)

14. Maiden name S

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

16. (a) Informant's own signature Harry Williams

(b) Address Ballinger Mo

17. (a) Burial (b) Date thereof 9.20.39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director D. G. Shell

(b) Address Mober

19. (a) 9.20.39 (b) Mrs. J. B. Berry
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Ballinger
(c) City or town Ballinger
(If outside city or town limits, write "RURAL")
(d) Street No. Rural (If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 19th year 1939 hour 9:00 minute 0 M.

21. I hereby certify that I attended the deceased from Sept. 15, 1939, to Sept. 19, 1939; that I last saw her alive on Sept. 19, 1939; and that death occurred on the date and hour stated above.

Immediate cause of death Malaria

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 _____

23. Signature Dr. R. B. Smith (M. D. or other) DO

Address Ballinger, Mo. Date signed 9/20/39

PHYSICIAN

Underline the cause to which death should be charged statistically.

APR 1 1948

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 with the above constitutes grounds for revocation of license.)

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