

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

36496
Do not use this space.

1. PLACE OF DEATH
 (a) County Dallas Registration District No. 461
 (b) Township _____ Primary Registration District No. 3024
 (c) City St. Louis (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 Jennie L. 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 14, 1865

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>74</u>	<u>5</u>	<u>23</u>	

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

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) Boston Ky

FATHER

13. NAME Benjamin Leslie

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

MOTHER

15. MAIDEN NAME Jennie P. Russell

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

17. INFORMANT (ADDRESS) Mr. Clyde Williams Lexington Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Truckner Mo DATE Dec. 9, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) H. Imbler Lexington Mo

20. FILED No 4 1939 Delia Bates Local Registrar.

MEDICAL CERTIFICATE OF DEATH

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

22. I HEREBY CERTIFY, That I attended deceased from Oct. 1, 1939, to Oct 7, 1939
 I last saw him/her alive on Oct. 7, 1939 Death is said to have occurred on the date stated above, at 8:30 P. m.
 The principal cause of death and related causes of importance were as follows:
Coronary occlusion
Heart Failure

Other contributory causes of importance: 94 lb

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? no
 If so, specify _____
 (Signed) J. S. Cooper M. D.
 (Address) Lexington, Mo

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

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.

30M-9-19-38 I X18603

NOV 2 1939

RECEIVED
District Health Officer No. 8,
District File Number 11/9/34
Date Filed

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

Geo. A. McKean

Licensed Embalmer No.

2783

P. O. Address

Leungton, 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.