

FILED FEB 15 1940

Registration District No. 50

Primary Registration District No. 3604

Registrar's No. 11

## 1. PLACE OF DEATH:

(a) County. BATES  
(b) City or town. BUTLER MO  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 2

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)In this community \_\_\_\_\_  
years, months or days) 453. (a) PRINT FULL NAME REVA LOU WILLIAMSON3. (b) If veteran, name war X 3. (c) Social Security No. X4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced WIDOWED

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased. MARCH 9 - 1939  
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day  
0 10 19 hr. min.9. Birthplace. BUTLER MO -  
(City, town, or county) (State or foreign country)10. Usual occupation none

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name. VERGIL WILLIAMSON18. Birthplace GRANT CITY MO.  
(City, town, or county) (State or foreign country)14. Maiden name ELBERTHA SCOTT15. Birthplace OKLAHOMA -  
(City, town, or county) (State or foreign country)16. (a) Informant's own signature Vergil Williamson(b) Address BUTLER MO17. (a) Burial (b) Date thereof Jan-30-40  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation OAKHILL CEM -18. (a) Signature of funeral director Booths - Butler Mo(b) Address Butler Mo - 5319. (a) Jan 30 1940 (b) Nemo & Culver  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State. MO (b) County. BATES(c) City or town. BUTLER  
(If outside city or town limits, write "RURAL")(d) Street No. \_\_\_\_\_  
(If rural, give location)

(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN. day 28  
year 1940 hour 10 minute 20 P. M.21. I hereby certify that I attended the deceased from Butler  
1-7- 1940, to 1-28- 1940that I last saw her, alive on 1-27-40 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Malnutrition

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 W. Woodard (M. D. or other)Address Butler, Mo. Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline  
the cause to  
which death  
should be  
charged statistically.

155

RECEIVED

District Health Officer No. 7.

District File Number 2-402-47

Date Filed 2-13-40.

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 the above constitutes grounds for revocation of license.)

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

No. Embalmed

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

1609  
Do not use this space.

1. PLACE OF DEATH

(a) County Bates

Registration District No. 50

(b) Township Butler

Primary Registration District No. 3004

Registered No. 11

(c) City Butler

(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.

2. PRINT FULL NAME Reva Lou Williamson

(a) Residence, No. \_\_\_\_\_ 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

MEDICAL CERTIFICATE OF DEATH

3. SEX 7 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) mf

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 28 1940

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

22. I HEREBY CERTIFY That I attended deceased from 19\_\_\_\_ to 19\_\_\_\_

I last saw h..... alive on....., 19..... Death is said to have occurred on the date stated above, at..... m.

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

The principal cause of death and related causes of importance were as follows:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min. 10 19

malnutrition Date of onset 10/15/39

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

Other contributory causes of importance: no info

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

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

13. NAME

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

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

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)

15. MAIDEN NAME

Specify whether injury occurred in industry, in home, or in public place.

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

Manner of injury \_\_\_\_\_

17. INFORMANT (ADDRESS)

Nature of injury \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL PLACE \_\_\_\_\_ DATE \_\_\_\_\_, 19\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

19. FUNERAL DIRECTOR (ADDRESS)

If so, specify \_\_\_\_\_

20. FILED \_\_\_\_\_, 19\_\_\_\_ Local Registrar, \_\_\_\_\_

(Signed) A. G. Woodbridge, M. D.

(Address) Butler mo

SUPPLEMENT

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS F

USUAL CLAIR in pen terms, to what it may be properly classified. Exact statement of OCCUR. XI

