DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 1779

Registration District No. MAR FEB 17 1940

Primary Registration District No. 82-51

Registrar's No. 1

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town Easton Mo. Marion Twn.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether
In this community 86 yrs. and 4 months
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan

(c) City or town ____
(If outside city or town limits, write "RURAL")

(d) Street No. Easton Mo. Rural
(If rural, give location)

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

3. (a) PRINT FULL NAME Mary Jane Williams

3. (b) If veteran, name war ____

3. (c) Social Security No. ____

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife George Wilson Williams

6. (c) Age of husband or wife if alive ____ years

7. Birth date of deceased 5 (Month) - 11 (Day) - 1854 (Year)

8. AGE: Years 86 | Months 4 | Days — | If less than one day ____ hr. ____ min.

9. Birthplace Dekalb Co. Mo. (City, town, or county) U S A. (State or foreign country)

10. Usual occupation House wife

11. Industry or business Farmer

FATHER
12. Name William Henry Sifers
13. Birthplace Penn. (City, town, or county) U.S.A. (State or foreign country)

MOTHER
14. Maiden name Matilda Slaybaugh
15. Birthplace Buchanan Co (City, town, or county) U.S.A. (State or foreign country)

16. (a) Informant's own signature J. C. Boyer

(b) Address Easton Mo. R.R. #2.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 13-1940. (Month) (Day) (Year)

(c) Place: burial or cremation In Dean Sunset Cemetery near Kansas Mo.

18. (a) Signature of funeral director F. G. Lyon

(b) Address Stewartsville Mo.

19. (a) 1/12-40 (Date received local registrar) (b) D. F. Bigham Fred (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 11 year 1940 hour 4 minute 15 P. M.

21. I hereby certify that I attended the deceased from Jan 5, 1940, to Jan 11, 1940, that I last saw her alive on Jan 11, 1940, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Bronchopneumonia	Jan 4, 1940
Due to	
Due to Chronic Nephritis	age 6 mo.
Other conditions (Include pregnancy within 3 months of death): Cancer of Breast	?
Major findings: Of operations 50	
Of autopsy	

PHYSICIAN — Underline the cause to which death should be charged statistically.

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? ____ (Specify type of place)

While at work? ____ (e) Means of injury ____

23. Signature J. M. Autem (M. ~~D. or other~~) D.O.

Address Stewartsville Mo. Date signed 1/12/40

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

Rev. 5-17-39 I X19311

RECEIVED
District Health Officer No. 11,
District File Number 240-136
Date Filed FEB 13 1948

RECEIVED
District Health Officer No. 11
District File Number
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 F. G. Lyon

Licensed Embalmer No. 952

P. O. Address Stewartsville, 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.

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

1779
Do not use this space.

1. PLACE OF DEATH
(a) County Buchanan Registration District No. 82
(b) Township Marion Primary Registration District No. 3123 Registered No.
(c) 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.

2. PRINT FULL NAME Mary Jane Williams
(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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 5-11-1854

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

OCCUPATION
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

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

FATHER
13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 2/10 1940 D. F. Bigham M.D.
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-11 1940

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

Date of onset

Other contributory causes of importance:

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?
If so, specify
(Signed) M. Auten, M. D.
(Address) Stewartsville Mo

SUPPLEMENTARY

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.