

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.

MAY 8 1940
Registration District No. 52229

State File No. _____

Primary Registration District No. 2046

Registrar's No. 6259

1. PLACE OF DEATH:

(a) County Barry
(b) City or town Rural - Crane Creek
(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 2
(Specify whether
In this community _____
years, months or days) 450

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Barry
(c) City or town Rural - Crane Creek
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Amanda P. Williams

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced married

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

7. Birth date of deceased June 8 1870
(Month) (Day) (Year)

8. AGE: Years 69 Months 10 Days 8 If less than one day _____ hr. _____ min.

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

10. Usual occupation house wife

11. Industry or business _____

12. Name John Ellis

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

14. Maiden name _____ (State or foreign country)

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

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

(b) Address Crane Mo

17. (a) Burial (b) Date thereof 4-18-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation mass trial

18. (a) Signature of funeral director She H. Munkler

(b) Address Crane Mo

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 16
year 1940 hour 6:20 PM minute _____ M.

21. I hereby certify that I attended the deceased from April 15
1940, 19 _____ to April 16, 1940
that I last saw her alive on April 16
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis Duration 36 hrs.

Due to Arteriosclerosis
Due to Hypertensive heart disease

Other conditions _____ (Include pregnancy within 3 months of death) 96 lbs

Major findings:
Of operations _____
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?

23. While at work? _____ (Specify type of place)
(e) Means of injury _____

24. Signature A. P. Foster (M. D. or other) MD
Address Crane, Mo Date signed 4-17-1940

RECEIVED

District Health Officer No. 6,

District File Number 540-1224

Date Filed MAY 6 1940

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.....

George H. Maulsby, Registered Apprentice No.....
working under my personal supervision.

Signed George H. Maulsby

6
Licensed Embalmer No. 3827

P. O. Address Chronic Inc.

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 14192

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 29

Primary Registration District No. 5046

Registrar's No. 23

1. PLACE OF DEATH:

(a) County. Barry
(b) City or town. Crane Creek
(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.
In this community. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State. (b) County.
(c) City or town. (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.

3. (a) PRINT FULL NAME

Amanda R. Williams

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex. F.

5. Color or race. W

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

6. (b) Name of husband or wife. W.N. Williams

6. (c) Age of husband, or wife, if alive. 8 years

7. Birth date of deceased. June (Month)

1940 (Year)

8. AGE:

Years 69 Months 10 Days 8

If less than one day min.

9. Birthplace.

(City, town, or county) (State or foreign country)

10. Usual occupation.

Housewife

11. Industry or business

MOTHER FATHER

12. Name. John Elder

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

14. Maiden name. Nancy Jane Wilson

15. Birthplace. Bradley Co. Iowa (City, town, or county) (State or foreign country)

16. (a) Informant.

Burkes P. Williams

(b) Address.

Crane mo

17. (a)

(b) Date thereof. (Month) (Day) (Year)

(c) Place: burial or cremation.

18. (a) Signature of funeral director.

Geo. H. Maulou

(b) Address.

Crane mo

19. (a)

10-9-1940 (Date received local registrar)

(b) Geo. W. Neuman (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH. Month. Apr day. 16 year. 1940 hour. minute. M.

21. I hereby certify that I attended the deceased from 19 to 19 that last saw him alive on and that death occurred on the date and hour stated above.

Immediate cause of death. Coronary thrombosis

arterio sclerosis

Hypertensive Heart disease

Other conditions. (Include pregnancy within 3 months of death)

Major findings: Of operations.

Of autopsy.

Duration

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?

While at work? (Specify type of place) (e) Means of injury.

23. Signature. A. P. Capelli (M. D. or other)

Address. Crane mo Date signed

WRITE PLAIN INK—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

TEMPORARILY

Reg. m. m.

