

Registration District No. **198** Primary Registration District No. **3011**

1. PLACE OF DEATH:  
(a) County Clay  
(b) City or town Excelsior Springs  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
209 West Excelsior St.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community About five years  
years, months or days)

3. (a) PRINT FULL NAME John Andrew Williams 452  
8. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife Elizabeth Williams 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased January 3 1848  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>92</u>	<u>5</u>	<u>21</u>	hr. _____ min. _____

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

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_  
12. Name William Cox Williams  
13. Birthplace Ohio  
(City, town, or county) (State or foreign country)  
14. Maiden name Jemima Camplen  
15. Birthplace Kentucky  
(City, town, or county) (State or foreign country)

16. (a) Informant Cora McCallum  
(b) Address Excelsior Springs, Missouri

17. (a) Burial (b) Date thereof June 25, 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Excelsior Sps. Mo

18. (a) Signature of funeral director Clarence Mehan  
(b) Address Excelsior Sps Mo  
19. (a) June 25, 1940 (b) Mrs Red McCracken  
(Data received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Clay  
(c) City or town Excelsior Springs  
(If outside city or town limits, write "RURAL")  
(d) Street No. 209 W. Excelsior St.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month June 24 day \_\_\_\_\_ year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from June 2 1940, to June 24 1940  
that I last saw him alive on June 22 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Septic Conventina  
Cardiac failure of  
Circulation collapse  
Due to Senility - 72 yrs of age  
Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

PHYSICIAN  
Major findings: Of operations none  
Of autopsy none  
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? no  
(Specify type of place) \_\_\_\_\_  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
23. Signature Arthur H. Dawson (M. D. or other) \_\_\_\_\_  
Address Excelsior Springs - Mo Date signed 6-24-40

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

X21492

200A

RECEIVED  
District Health Officer, No. 8  
District File Number  
Date Filed 7-16-40

**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.....

**Robert Ray**

Registered Apprentice No. **226**

working under my personal supervision.

Signed *Claude Richard*

Licensed Embalmer No. **2751**

P. O. Address *Excelsior Spex, Minn*

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. 21528-

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 198

Primary Registration District No. 3011

Registrar's No.

R

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

1. PLACE OF DEATH:

(a) County Ray

(b) City or town Walcarron Springs  
(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 \_\_\_\_\_ (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 John Andrew Williams

(b) If veteran name war \_\_\_\_\_

(c) Social Security No. \_\_\_\_\_

20. DATE OF DEATH Month June day 24 year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

4. Sex m 5. Color or race w

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

6. (c) Age of husband, or wife, if alive \_\_\_\_\_ year

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

7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

92 5 21 \_\_\_\_\_ min.

Immediate cause of death acute congestive Cardiac failure

Circulatory collapse

Due to myocarditis

chronic

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

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

10. Usual occupation \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

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

Of autopsy \_\_\_\_\_

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country) \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_

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

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) \_\_\_\_\_ (Means of injury)

23. Signature Lester V Dawson (M. D. or other) \_\_\_\_\_ Address Walcarron Springs Mo

SUPPLEMENTARY

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

