. No. 2
-11-10-39
5-17-39 -
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

AUG 6 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 25711

Registration District No. 547 Primary Registration District No. 3029 Registrar's No. 195

1. PLACE OF DEATH:

(a) County Marion

(b) City or town Hannibal
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 604 Olive 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 _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Marion

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

(d) Street No. 604 Olive
(If rural, give location)

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

3. (a) PRINT FULL NAME George W. Williams 45

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

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

7. Birth date of deceased Nov. 14. 1869
(Month) (Day) (Year)

8. AGE: Years 70 Months 7 Days 2 If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) Indiana (State or foreign country) 1

10. Usual occupation Brick Layer 1

11. Industry or business 1

FATHER
12. Name Joseph Williams
13. Birthplace _____ (City, town, or county) N. Carlina (State or foreign country)

MOTHER
14. Maiden name Catherine Crews
15. Birthplace _____ (City, town, or county) Indiana (State or foreign country)

16. (a) Informant Florence Williams
(b) Address 604 Olive Hannibal Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June 19-1940 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Olivet Cem

18. (a) Signature of funeral director James O'Donnell
(b) Address Hannibal Mo

19. (a) 7-1-40 (Date received local registrar) (b) N. C. Fisher (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 16
year 40 hour 10.45 minute P M.

21. I hereby certify that I attended the deceased from 1-29-38, 19__, to 6-16, 1940
that I last saw him alive on 6-16, 1940
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cirrhosis of liver with acites	6 mo.
Due to Cardiac Trouble	
Due to Diabetes	
Other conditions None (Include pregnancy within 3 months of death) 54	
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? 4 00 (Specify type of place)
While at work? _____ (e) Means of injury _____

23. Signature J. C. Philton (M. D. or other) 1
Address 500 Broadway Date signed 6-18-40

(Licensed Embalmer's Statement on Reverse Side)

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 Michael J O'Connor

Licensed Embalmer No. 3246

P. O. Address Hannibal, 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.