

Registration District No. 678

Primary Registration District No. 5904

Registrar's No. _____

1. PLACE OF DEATH

(a) County Phelps
 (b) City or town St James
 (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
 In this community 36 yrs
 years, months or days (Specify whether)

3. (a) PRINT FULL NAME William Earl Williams

3. (b) If veteran, name war _____ 3. (c) Social Security No. 1189-16-3219

4. Sex Male 5. Color or race White
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Nancy Williams
 6. (c) Age of husband or wife if alive 39 years
 7. Birth date of deceased May 22, 1904
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>36</u>	<u>3</u>	<u>8</u>	hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business _____

MOTHER { 12. Name Geo Williams
 13. Birthplace Phelps Mo
 (City, town, or county) (State or foreign country)
 14. Maiden name Delia Perry
 15. Birthplace S. C.
 (City, town, or county) (State or foreign country)

16. (a) Informant Geo Williams

(b) Address St James Mo

17. (a) Burial (b) Date thereof 9-1-40
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Macon cem

18. (a) Signature of funeral director W. R. Richlender

(b) Address St James Mo

19. (a) 9-2-40 (b) Elmer B. Dault
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Phelps
 (c) City or town St James
 (If outside city or town limit, 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 8 day 30
 year 1940 hour 4:00 minute 0 M.

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

Immediate cause of death Myocardial Regeneration

Due to _____
 Due to 92 hr

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? 611
 While at work? _____ (Specify type of place) (e) Means of injury _____
 23. Signature Oral Richlender (M.D. or other) Coroner
 Address St James Mo Date signed 8-31-40

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

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

RECEIVED

District Health Officer No. 5,

District File Number 940 927

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

Carl Liebler

Licensed Embalmer No. 35-46

P. O. Address St James M

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.