

FILED NOV 25 1940

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH36545  
Do not use this space.

## 1. PLACE OF DEATH

(a) County Stoddard Registration District No. 834  
 (b) Township Snake Primary Registration District No. 4506  
 (c) City Bell 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.

Registered No. 32

## 2. PRINT FULL NAME

Mollie Williamson  
 (a) Residence, No. Bell City, Mo 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Edward Harrison William

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan. 23, 1971

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
69 7 11

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife

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) Jackson, Mo.

FATHER 13. NAME Louise Macke

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

MOTHER 15. MAIDEN NAME Caroline Frieze

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Not known

17. INFORMANT (ADDRESS) J. C. Williamson

18. BURIAL, CREMATION, OR REMOVAL PLACE Desert Home Cemetery, Mo. DATE Sept. 6, 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Leola Morgan

20. FILED Oct 30, 1940 D. S. McKeel Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept. 6, 1940

22. I HEREBY CERTIFY, That I attended deceased from 9/4, 1940, to 9/4, 1940

I last saw her alive on 9/4, 1940 Death is said to have occurred on the date stated above, at 1:30 P.M.

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

Heart Failure  
due to subnormal innervation

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? no  
If so, specify \_\_\_\_\_

(Signed) C. O. Bennett, M. D.  
(Address) Bell City, Mo.

75152

RECEIVED

District Health Officer No. 2,

District File Number 1140-16

Date Filed 11/6/40

**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,

*Hoyd S. Morgan*

, or by

Registered Apprentice No. \_\_\_\_\_, working under my personal supervision

Signed

*Hoyd S. Morgan*

Licensed Embalmer No. 3361

P. O. Address Adrian, 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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 36-545-7

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
Registration District No. 834

Primary Registration District No. 4506

Registrar's No. 22

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

1. PLACE OF DEATH:  
(a) County Stoddard  
(b) City or town Bell City  
(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 Mollie Williamson  
3. (b) If veteran, name war..... 3. (c) Social Security No.....

20. DATE OF DEATH: Month Sept day 4  
year 1940 hour..... minute..... M.  
21. I hereby certify that I attended the deceased from..... 19..... to..... 19.....  
that I last saw h..... alive on..... 19.....  
and that death occurred on the date and hour stated above.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced wid  
6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... year.....

Immediate cause of death.....

8. AGE: Years 69 Months 7 Days 11 If less than one day..... h..... min.....

Heart failure due to subnormal function  
Due to Myocarditis  
Other condition..... (Include pregnancy within 3 months of death)  
Duration

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

10. Usual occupation.....

11. Industry or business.....

12. Name.....

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

14. Maiden name.....

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).....

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?.....

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

23. Signature C. O. Bennett (M. D. or other).....

Address..... Date signed 7-11-40

SUPPLEMENTAL COPY

