

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

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.

JAN 10 1941
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

41810
State File No. _____
Registrar's No. 278

Registration District No. 73 Primary Registration District No. 3006

1. PLACE OF DEATH:
(a) County Boone
(b) City or town Columbia
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution no
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community Life
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Boone
(c) City or town Columbia Mo
(If outside city or town limits, write "RURAL")
(d) Street No. 114 - 2nd AV
(If rural, give location)
(e) If foreign born, how long in U. S. A. Life years.

3. (a) PRINT FULL NAME Eugene Williamson
3. (b) If veteran, name war no
3. (c) Social Security No. no

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Dec day 23rd
year 1940 hour 8 minute 45 P. M.

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Emily Williamson
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased July 17 1876
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from December 21, 1940, to Dec 23, 1940, that I last saw him alive on Dec 21, 1940, and that death occurred on the date and hour stated above.

8. AGE: Years 64 Months 5 Days 6 If less than one day _____ hr. _____ min.

Immediate cause of death Pneumonia bronchial Duration 3 days
Due to Chronic bronchitis for a number of years
Due to _____

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

Other conditions none
(Include pregnancy within 3 months of death)

10. Usual occupation Laborer
11. Industry or business _____
12. Name Charles D Williamson
13. Birthplace DK
14. Maiden name Emma Williamson
15. Birthplace DK
(City, town, or county) (State or foreign country)

Major findings: Of operations no op
Of autopsy none
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant's own signature Record of Social Security
(b) Address Columbia
17. (a) Burial (b) Date thereof Dec 24 40
(Burial, cremation, or reburial) (Month) (Day) (Year)
(c) Place: burial or cremation Fairview Cem
18. (a) Signature of funeral director R. A. Wittcraft
(b) Address Columbia, Mo
19. (a) 12/24/40 (b) Allie Selby
(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) no
(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 AW Williamson (M. D. or other) _____
Address Columbia, Mo Date signed 12-23-40

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

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.