

No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

43028

State File No. _____

JAN 17 1941

Registration District No. 464

Primary Registration District No. 42075-5626 Registrar's No. 50

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

1. PLACE OF DEATH:

(a) County Lafayette

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

(c) Name of hospital or institution:
Route 1, Box 15
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
In this community 90 yrs. Home 15 days
years, months or days (Specify whether _____)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lafayette

(c) City or town Rural, Jefferson, Mo.
(If outside city or town limit, write "RURAL")

(d) Street No. Route 1, Box 15
(If rural, give location)

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

8. (a) PRINT FULL NAME Charles A. Williams

8. (b) If veteran, _____ name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 16
year 1940 hour 7 minute P M.

4. Sex Male 5. Color or race Negro

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased January 15 1850
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Dec 3, 1940, to _____, 19____; that I last saw him alive on Dec 3, 1940 and that death occurred on the date and hour stated above.

8. AGE: Years 90 Months 11 Days 15 If less than one day _____ hr. _____ min.

Immediate cause of death
Pneumonia (hypostatic)

Due to Fracture neck of rt. femur 1 mi?

Due to _____

Other conditions Incarcerated w. original tumor
(include pregnancy within 3 months of death)

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

10. Usual occupation Clerk

11. Industry or business Hardware

12. Name unknown

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

14. Maiden name unknown

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

Major findings:
Of operations _____

Of autopsy _____

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

16. (a) Informant Father Warren

(b) Address Rural, Route 1, Box 15

17. (a) Burial (b) Date thereof 12-19-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Lebanon Cem.

18. (a) Signature of funeral director Weyand

(b) Address 2036 N. 4th St. Jefferson, Mo.

19. (a) 12-17-40 (b) More E. M. [unclear]
(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? _____

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

23. Signature [Signature] (M. D. or other) _____
Address Hedgesville Date signed Dec 8 40

Mrs. E. M. Goodwin
Registrar address.

1442
99

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 1-7-41

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.....

George H. Hunt

Registered Apprentice No. *235*

working under my personal supervision.

Signed.....

William Hunley

Licensed Embalmer No. *3105*
2045 South 24th Street
P. O. Address *Lexington, Md.*

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. 43028

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 464

Primary Registration District No. 6226

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Lafayette
(b) City or town Wagon 7 P
(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)

3. (a) PRINT FULL NAME Chas A Williams

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

4. Sex m 5. Color or race negro 6. (a) Single, widowed, married, divorced wid

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

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

8. AGE: Years 90 Months 11 Days 15 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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)

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.

DEATH CERTIFICATION

20. DATE OF DEATH: Month Dec day 18 year 1948 hour _____ minute _____ 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 Bronchitis pneumonia
Fract head of left femur
Due to _____

Due to _____
Other conditions _____ (Include pregnancy within 3 months of death) 186 W
18

Major findings: _____
Of operations _____
Of autopsy _____

Duration _____

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) Fall from bed

(b) Date of occurrence Nov 12, 1948

(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? Fell out of bed at home
While at work? no (Specify type of place) (e) Means of injury Fall

23. Signature O. T. Jessel (M. D. or other) _____

Address Higginsville Mo Date signed _____

SUPPLEMENTAL

S-43028