Dr 8 6 7 Rec.

FILED JAN 25 1941

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

43485
Do not use this space.

1. PLACE OF DEATH
(a) County: Phelps — Registration District No. 677
(b) Township or (c) City: Rolla — Primary Registration District No. 4403 — Registered No. 144
(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.

2. PRINT FULL NAME: Phillis R. Williams
(a) Residence, No. Rolla Mo O 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*): Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Aug 1 - 1940
7. AGE: Years —; Months 4; Days 4; If LESS than 1 day, ____ hrs. or ____ min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
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): Rolla Missouri

FATHER
13. NAME: Harry Williams
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Hooker Mo.

MOTHER
15. MAIDEN NAME: Virginia Hargis
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Phelps Co Mo.

17. INFORMANT (ADDRESS): Harry Williams Rolla Mo

18. BURIAL, CREMATION, OR REMOVAL
PLACE: Mt Olive Cem DATE: 12/6 19 40

19. FUNERAL DIRECTOR (NAME) (ADDRESS): Mrs. Harry McCaw Rolla Mo

20. FILED: Dec. 5 1940 Jos. F. Ayers Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): 12/4 19 40

22. I HEREBY CERTIFY, That I attended deceased from 12-1- 1940, to ____ 19____
I last saw him alive on 12-4- 1940, Death is said to have occurred on the date stated above, at 7:40 p.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Bronchopneumonia	12-1-40

Other contributory causes of importance:

Name of operation ____ Date of ____
What test confirmed diagnosis? ____ Was there an autopsy? no

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) E. E. Fend, M. D.
(Address) Rolla mo.

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY, WITH UNFADING INK—THIS IS 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.

X16805

RECEIVED
District Health Officer No. 5,
District File Number 1240/228
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.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

. No. 2B
—2-21-40
I X22659

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 43485

Registration District No. 677 Primary Registration District No. 4403 Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Phelps

(b) City or town Rolla
(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 (Specify whether
In this community 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 Phillis R Williams

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex 7

5. Color or race W

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

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 | Months 4 | Days 4 | If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

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

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 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.

Immediate cause of death Bronchopneumonia — Duration 24 hrs.

Due to no complications

Due to

Other conditions 107a
(Include pregnancy within 3 months of death)

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

23. Signature E. E. Feind M.D. (M. D. or other)
Address Rolla mo. Date signed

S-43485