No. 2
5-17-39
PI X23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 9 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 17778

Registration District No. 309 Primary Registration District No. 4185 Registrar's No. 25

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

1. PLACE OF DEATH:
(a) County: Gentry County
(b) City or town: Albany
(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 years, months or days) In this community .....

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Gentry 38
(c) City or town: Albany 1 (If outside city or town limits, write "RURAL") 0
(d) Street No. ..... (If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME: Emily Ann Williams
3. (b) If veteran, name war .....
3. (c) Social Security No. .....
4. Sex: Female
5. Color or race: White
6. (a) Single, widowed, married, divorced: Widowed
6. (b) Name of husband or wife: John S. Williams
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased: Sept. (Month) 10 (Day) 1846 (Year)
8. AGE: Years 94 Months 8 Days 15 If less than one day ..... hr. ..... min.
9. Birthplace: Albany (City, town, or county) 0 Missouri (State or foreign country)
10. Usual occupation: Housewife
11. Industry or business .....
MOTHER FATHER
12. Name: Andrew Jackson Bulla
13. Birthplace: Unknown (City, town, or county) 9 (State or foreign country)
14. Maiden name: Eliz. Ann Whitton
15. Birthplace: Virginia (City, town, or county) / (State or foreign country)
16. (a) Informant: Mary Williams
(b) Address: St. Joseph, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 5/27/41 (Month) (Day) (Year)
(c) Place: burial or cremation: Grandview
18. (a) Signature of funeral director: Clifford Brooks
(b) Address: Albany Mo
19. (a) May 27, 1941 (Date received local registrar) (b) W. T. Martin (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 25 year 1941 hour 11 minute P.M.
21. I hereby certify that I attended the deceased from August — 1924 to May 25 — 1941; that I last saw her alive on May 25 — 1941; and that death occurred on the date and hour stated above.

Immediate cause of death: Hypostatic Pneumonia — Duration 5-23-41
Due to .....
Due to .....
Other conditions (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: Frank H. Ross (M. D. or other) MD
Address: Albany, Mo. Date signed 5-26-41

(Licensed Embalmer's Statement on Reverse Side)

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 me

, Registered Apprentice No.

working under my personal supervision.

Signed Clifford Burke

Licensed Embalmer No. 3329

P. O. Address Albany Mo

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

If this body is not embalmed, fact should be so stated above.

S. No. 2B
0—4-25-41
I X27852

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

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1. PLACE OF DEATH:
(a) County Gentry
(b) City or town Albany
(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 years, months or days)
In this community

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) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Emily Ann Williams
3. (b) If veteran, name war
3. (c) Social Security No.
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
7. Birth date of deceased (Month) (Day) (Year)
8. AGE: Years 94 Months 8 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
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 May day 25
year 1941 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.

	Duration
Immediate cause of death Hypostatic Pneumonia	
Due to (Lobar)	
Due to 108	
Other conditions (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 Frank H. Roe (M. D. ~~or other~~)
Address Albany, Mo. Date signed

SUPPLEMENTARY

S-17778