

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

22832
Do not use this space.

OF DEATH

(a) County Saline Registration District No. 796

(b) Township _____ Primary Registration District No. 3038 Registered No. 110

(c) City Marshall (d) Street No. _____ (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 Patria Jane Williams

(a) Residence, No. _____ St. (If nonresident, give city or town and State)

(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) N

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar 19 1941

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>0</u>	<u>3</u>	<u>11</u>	

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

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) Marshall, Mo.

13. NAME Russel F. Williams

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Houstonia, Mo.

15. MAIDEN NAME Crystal B. Carter

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Bellville, Kansas

17. INFORMANT (ADDRESS) Crystal Williams, Marshall, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Houstonia, Mo. DATE 6-30-41

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Thatcher, Houstonia, Mo.

20. FILED 6-30-41 Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-30-41

22. HEREBY CERTIFY, That I attended deceased from May 6, 1941, to June 30, 1941

I last saw him alive on June 30, 1941. Death is said to have occurred on the date stated above, at 4:20 P.M.

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

Inanition
Pulverospasms
Chronic intestinal indigestion

Date of onset May 5
July 28
May 5

Other contributory causes of importance: Prematurity 6 1/2 to 7 mo.

Name of operation _____ Date of _____

What test confirmed diagnosis? 159 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) J. E. Hadden
 (Address) Marshall, Mo.

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.

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 7-10-41

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

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

Signed..... *H. H. Smiley*

Licensed Embalmer No. *3987*

P. O. Address..... *Houston*

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. 22832

Registration District No. 796

Primary Registration District No. 3038

Registrar's No. 110

1. PLACE OF DEATH:

(a) County Saline
 (b) City or town _____
 (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

3. (a) PRINT FULL NAME Patricia 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 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 0 Months 3 Days 11 If less than one day _____ hr _____

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____
 18. 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's own signature _____
 (b) Address _____

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

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

19. (a) 8-22-41 Deputy Mary Kent
 (Date received local registrar's certificate) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Saline
 (c) City or town Marshall
 (If outside city or town limits, write "RURAL")
 (d) Street No. 1226 High
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 30
 year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings: _____
 Of operations _____

Of autopsy _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically

SUPPLEMENTARY

S-22832

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.