

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

FILED MAR 1942

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 6872

Registration District No. 395

Primary Registration District No. 5551A

Registrar's No.

48  
9

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

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Blue Springs  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Smabar Turp 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 73 yrs  
years, months or days

3. (a) PRINT FULL NAME

Rufus L. Williams

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex MO 5. Color or race W 6. (a) Single, widowed, married, divorced Widow  
6. (b) Name of husband or wife Ada 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased June 3 1868  
(Month) (Day) (Year)

8. AGE: Years 73 Months 8 Days 22 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Blue Springs Mo U  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer (Retired)

11. Industry or business \_\_\_\_\_

12. Name A. L. Williams

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

14. Maiden name Amanda Gibson

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

16. (a) Informant L. R. Williams

(b) Address Blue Springs Mo

17. (a) Burial (b) Date thereof 2-26  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Blue Springs Mo

18. (a) Signature of funeral director Mrs G. O. Wells, son

(b) Address Blue Springs Mo

19. (a) 3-3-42 (b) Mrs. Williams  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Blue Springs Mo  
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 26  
year 1942 hour 8:30 minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from Dec 28  
\_\_\_\_\_, 1941, to Feb 21, 1942  
that I last saw him alive on Feb 23, 1942  
and that death occurred on the date and hour stated above.

Immediate cause of death Left Hemiplegia

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death) 8301

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 J. P. Crayton M.D. (M. D. or other) \_\_\_\_\_  
Address Brain Valley Date signed 2-26-42

Duration

6 weeks

PHYSICIAN

Underline the cause to which death should be charged statistically.

1011

MO

**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.....

*R B Bleibb*

Licensed Embalmer No.....

*2353*

P. O. Address.....

*Blue Springs Mo*

**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, fact should be so stated above.**