. No. 2
—5-42
5-17-39
I X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 9 1942

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 35120

Registration District No. 577 Primary Registration District No. 6274 Registrar's No.

14
8
0

1. PLACE OF DEATH:
(a) County Wright
(b) City or town Graff (Montgomery Twp.)
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(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 Life

2. USUAL RESIDENCE OF DECEASED: 114
(a) State Missouri (b) County Wright 0
(c) City or town Graff (Rural) 0
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME William Warner Williamson
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex male 0
5. Color or race white
6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife Sarah Williamson
6. (c) Age of husband or wife if alive years
7. Birth date of deceased June (Month) 2 (Day) 1862 (Year)
8. AGE: Years 80 Months 4 Days 10 If less than one day hr. min.
9. Birthplace (City, town, or county) Kentucky 1 (State or foreign country)
10. Usual occupation Farmer
11. Industry or business
FATHER 12. Name Thomas Williamson
13. Birthplace (City, town, or county) unknown 9 (State or foreign country)
MOTHER 14. Maiden name Unknown
15. Birthplace (City, town, or county) unknown 9 (State or foreign country)
16. (a) Informant Mrs Nora Coble
(b) Address Graff Missouri
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 13, 1942 (Month) (Day) (Year)
(c) Place: burial or cremation Concord Cem. (Texas Co)
18. (a) Signature of funeral director [illegible]
(b) Address Mountain Grove Missouri
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 12 year 1942 hour 10 minute 30 P.M.
21. I hereby certify that I attended the deceased from Oct 1st, 1942, to Oct 12, 1942; that I last saw h. alive on Oct 6, 1942 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Coronary Occlusion	1 hr
Due to: Chronic Myocarditis	—
Due to:	
Other conditions (Include pregnancy within 3 months of death): 93b	

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 H. G. Frame (M. D. or other)
Address Mountain Grove Date signed 11-4-42

1644 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6,
District File Number 1142-1550
Date Filed NOV 6 1942

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 George Stapp

Licensed Embalmer No. 3161

P. O. Address Mtn Grove

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

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

S. No. 2B
M—8-21-41
I X29288

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. 35120

Registration District No. 377 Primary Registration District No. 6284 Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:
(a) County: Wright
(b) City or town: (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: Wm Warner Williamson
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex: M
5. Color or race: W
6. (a) Single, widowed, married, divorced: W
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased: June (Month) 2 (Day) 1862 (Year)
8. AGE: Years 80 Months 4 Days If less than one day hr. min.
9. Birthplace: (City, town, or county) Kentucky (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)
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) 2/3-43 (Date received local registrar) (b) Porter Hutsell (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Day year 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.

	Duration
Immediate cause of death	
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 (M. D. or other)
Address Date signed

35720