No. 2
5-42
5-17-39
X328

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 22 1943

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 9716

Registration District No. 42 | Primary Registration District No. 1000 | Registrar's No. 293

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

1. PLACE OF DEATH:
(a) County: Buchanan
(b) City or town: St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 421 So. 17th St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 years (Specify whether years, months or days)
In this community Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Buchanan
(c) City or town: St. Joseph
(If outside city or town limits, write "RURAL")
(d) Street No.: 421 So. 17th St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country: 0

3. (a) PRINT FULL NAME: Edwin Williams
3. (b) If veteran, name war: No
3. (c) Social Security No.: None
4. Sex: Male
5. Color or race: Colored
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Carrie
6. (c) Age of husband or wife if alive: 70 years
7. Birth date of deceased: January (Month) 14 (Day) 1869 (Year)

8. AGE: Years 74 | Months 1 | Days 26 | If less than one day ____ hr. ____ min.

9. Birthplace: Richmond (City, town, or county) Missouri (State or foreign country)
10. Usual occupation: Barber
11. Industry or business: Roubidoux Hotel

FATHER
12. Name: David Williams
13. Birthplace: Richmond (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name: Celie Mason
15. Birthplace: Richmond (City, town, or county) Missouri (State or foreign country)

16. (a) Informant: Carrie Williams (Wife)
(b) Address: 421 So. 17th St., City
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 3/10/43 (Month) (Day) (Year)
(c) Place: burial or cremation: Ashland Cemetery
18. (a) Signature of funeral director: LINCOLN MORTUARY.
(b) Address: ST. JOSEPH, MO.
19. (a) 3-10-43 (Date received local registrar) (b) Rae Herzog (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mch. day 4 year 1943 hour 2 minute 2 M.
21. I hereby certify that I attended the deceased from Nov. 17, 1942, to Mch. 4, 1943 that I last saw him alive on Mch. 8, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death: Uremia — Duration 4 days
Due to: Acute Nephritis — 10 days
Due to:
Other conditions (Include pregnancy within 3 months of death): Inguinal Hernia — Several Yrs
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: J. D. Dey M.D. (M. D. or other)
Address: 525 So. 16th St. St. Joseph, Mo. Date signed: 3-4-43

1255 (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~~ .....

....., Registered Apprentice No. .....,

working under my personal supervision.

Signed John E. Rupp

Licensed Embalmer No. 3986

P. O. Address St. Joseph 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.

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. 9716

Registration District No. 72 Primary Registration District No. 1000 Registrar's No. 293

1. PLACE OF DEATH:

(a) County: Buchanan

(b) City or town: St Joseph
(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: Edwin Williams

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex: M

5. Color or race: B

6. (a) Single, widowed, married, divorced: M

6. (b) Name of husband or wife: Carrie

6. (c) Age of husband or wife if alive: 70 years

7. Birth date of deceased: Jan (Month) 14 (Day) 1869 (Year)

8. AGE: Years 74 Months 1 Days 28 If less than one day hr. min.

9. Birthplace: Richmond (City, town, or county) Mo. (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)

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 Mar 24 Day year 1943 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.

Immediate cause of death: Uremia — Duration: 4 days

Due to: acute nephritis — Duration: 10 days

No Autopsy Not Given But

Due to: Acute attack of uremia

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

30

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

SUPPLEMENTARY