

FILED APR 5 1943 18
Registration District No. _____

Primary Registration District No. **3017**

Registrar's No. **44**

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

1. PLACE OF DEATH:

(a) County **COOPER**

(b) City or town **BOONVILLE**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
ST. JOSEPH'S HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **4 DAYS** (Specify whether)

In this community **30 YEARS** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **COOPER**

(c) City or town **BOONVILLE** (If outside city or town limits, write "RURAL")

(d) Street No. **1119 MAIN STREET** (If rural, give location)

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

3. (a) PRINT FULL NAME **REV. WALTER HENRY WILLIAMSON**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **MARCH** day **29th**
year **1943** hour **11:20** minute _____ AM.

3. (b) If veteran, name war **NONE**

3. (c) Social Security No. **496-01-6724**

21. I hereby certify that I attended the deceased from **Mar. 19 1943** to **Mar 29 1943**
that I last saw him alive on **Mar 29 1943**
and that death occurred on the date and hour stated above.

4. Sex **MALE**

5. Color or race **NEGRO**

6. (a) Single, widowed, married, divorced **WIDOWED**

6. (b) Name of husband or wife **LUCY WILLIAMSON**

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

7. Birth date of deceased **FEBRUARY 20 1882**
(Month) (Day) (Year)

Immediate cause of death **Cerebral Pneumonia 3 days**

Due to _____

Due to _____

8. AGE: Years Months Days If less than one day

61	1	9	hr. _____ min.
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Other conditions **Cancer of Kidney**
(Include pregnancy within 3 months of death)

9. Birthplace **VERSAILLES MISSOURI**
(City, town, or county) (State or foreign country)

Major findings: **Hyper tension**

Of operations _____

Of autopsy **Cancer Kidney Pneumonia**

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

10. Usual occupation **MINISTER & PORTER**

11. Industry or business **CHURCH & BARBER SHOP**

12. Name **THOMAS WILLIAMSON**

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

14. Maiden name **SARAH TYLER**

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

16. (a) Informant **MRS M. LUTHER**

(b) Address **KANSAS CITY, MO.**

17. (a) **BURIAL** (b) Date thereof **3/31/43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **CITY CEMETERY**

18. (a) Signature of funeral director **STEGNER & KOENIG**

(b) Address **BOONVILLE, MO.**

19. (a) **Mar. 29-43** (b) **Dr. Chas. Swap.**
(Date received local registrar) (Registrar's signature)

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.S. McGuire** (M. D. or other)

Address **Boonville, Mo.** Date signed **3/31/43**

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

4-2-43

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

James W. Stegner

Licensed Embalmer No.

3780

P. O. Address

Boonville, 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.