

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

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

FILED JUN 11 1943

17803  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Franklin Registration District No. 114  
 (b) Township Meramec Primary Registration District No. 4186 Registered No. 16  
 (c) City Sullivan (d) Street No. 1 St. 0  
 (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 Sharon Kay Willman  
 (a) Residence, No. Sullivan, Mo. St.  (If nonresident, give city or town and State) 0  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS				
3. SEX <b>Female</b>	4. COLOR OR RACE <b>White</b>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <b>Baby 0</b>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <b>none</b>				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <b>May, 12th, 1943</b>				
7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, <u>0</u> hrs. or <u>0</u> min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.			
	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) <b>Sullivan, Mo. 0</b>				
FATHER	13. NAME <b>C. F. Willman</b>			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <b>St. Louis, Mo. 0</b>			
MOTHER	15. MAIDEN NAME <b>Elsie Jacobs</b>			
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <b>St. Louis, Mo. 0</b>			
17. INFORMANT (ADDRESS) <b>C. J. Willman, Sullivan, Mo.</b>				
18. BURIAL, CREMATION, OR REMOVAL PLACE <b>Sullivan, Mo.</b> DATE <b>May, 13, 1943</b>				
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <b>J. T. Williams, Sullivan, Mo.</b>				
20. FILED <b>5/13</b> 19 <u>43</u> <b>Silbert Gilman</b> Local Registrar.				

MEDICAL CERTIFICATE OF DEATH	
21. DATE OF DEATH (MONTH, DAY, AND YEAR) <b>May, 12th, 1943</b>	
22. I HEREBY CERTIFY, That I attended deceased from <b>May 12, 1943, to May 12, 1943</b> I last saw her alive on <b>May 12, 1943</b> Death is said to have occurred on the date stated above, at <b>8:30 a. m.</b> The principal cause of death and related causes of importance were as follows: <b>Premature - 7 mos - Toxic condition of mother 12th</b> Other contributory causes of importance: <b>mother toxic - labor induced 15</b> Name of operation <b>Chemical</b> Date of <b>1943</b> What test confirmed diagnosis? <b>15</b> Was there an autopsy? <b>no</b>	
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? _____ If so, specify _____ (Signed) <b>C. A. Prater</b> , M. D. (Address) <b>Sullivan, Mo.</b>	

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**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.....

*J. T. Williams*

Licensed Embalmer No. 427.....

P. O. Address Sullivan, 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, above space should be left blank.**