

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

25959

State File No. \_\_\_\_\_

ED AUG 6 1943 16  
Registration District No. \_\_\_\_\_

Primary Registration District No. 6075

Registrar's No. 298

1. PLACE OF DEATH:

(a) County St. Francois  
(b) City or town Farmington- RURAL St. Francois  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Mo. State Hospital No. 4  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 5 yrs. 9 mos. 7  
days. (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME ETHEL WILLIAMSON

3. (b) If veteran, name war No 3. (c) Social Security No. Unk.

4. Sex Female 5. Color or race W. 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife None 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased August 5, 1898  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
44 10 29 hr. min.

9. Birthplace St. Francis Arkansas  
(City, town, or county) (State or foreign country)

10. Usual occupation None

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

MOTHER FATHER { 12. Name John Williamson

13. Birthplace Unknown 9  
(City, town, or county) (State or foreign country)

14. Maiden name Nanny McFarlin

15. Birthplace Clay County, Illinois  
(City, town, or county) (State or foreign country)

16. (a) Informant Records State Hospital No. 4

(b) Address Farmington, Missouri

17. (a) Burial (b) Date thereof 7-5-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hospital Cem., Farmington, Mo.

18. (a) Signature of funeral director Miller Funeral Home

(b) Address Farmington, Missouri

19. (a) July 6 1943 (b) Sydney Bukhmaster  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County New Madrid 94  
(c) City or town Marston  
(If outside city or town limits, write "RURAL")  
(d) Street No. Unk.  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 5  
year 1943 hour 9 minute 55 A. M.

21. I hereby certify that I attended the deceased from April 12  
1943, to July 4, 1943,  
that I last saw her alive on July 3, 1943,  
and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis 1 mo.

Due to 932

Due to Paraphrenia with Epilepsy 6 yrs.  
Other conditions Epileptic deterioration  
(Include pregnancy within 3 months of death)

PHYSICIAN  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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?  
While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury 0

23. Signature John Arndale (M. D. or other)  
Address State Hospital #4 Date signed 7/5/43

RECEIVED

District Health Officer No. \_\_\_\_\_

District File Number 843

Date Filed 8-5-

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 \_\_\_\_\_

*Not Embalming*  
working under my personal supervision.

Registered Apprentice No. \_\_\_\_\_

Signed *Bert J. Miller*

Licensed Embalmer No. 3752

P. O. Address *Farmington,*

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.