

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

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 29 1944

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 3638

Registration District No. 227

Primary Registration District No. 3046

Registrar's No. 148

1. PLACE OF DEATH:

(a) County MONITEAU

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

(c) Name of hospital or institution: LATHAM HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community JAMES ALLIE years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County MILLER 66

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

(d) Street No. SALINE
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____ 1

3. (a) PRINT FULL NAME JAMES ALLIE WILLIAMS

3. (b) If veteran, name war No

3. (c) Social Security No. No

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month FEB day 3
year 1944 hour 5 minute 30 A.M.

21. I hereby certify that I attended the deceased from January 26 1944 to Feb 3 1944
that I last saw him alive on Feb 3 1944
and that death occurred on the date and hour stated above.

4. Sex FEMALE 5. Color or race WHITE

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

6. (b) Name of husband or wife JAMES WILLIAMS

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

7. Birth date of deceased Aug. 13 1883
(Month) (Day) (Year)

8. AGE:			If less than one day
Years	Months	Days	
<u>60</u>	<u>5</u>	<u>22</u>	hr. _____ min.

Immediate cause of death Cerebral hemorrhage Duration 6 days

Due to Pneumonia 7 days

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

9. Birthplace Osage Mo. I
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name James R. Russell

13. Birthplace Mo. I
(City, town, or county) (State or foreign country)

14. Maiden name Summe Currence

15. Birthplace Mo. I
(City, town, or county) (State or foreign country)

16. (a) Informant Paul William

(b) Address Osage, Mo.

17. (a) Burial (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Eldon Cemetery

18. (a) Signature of funeral director Phillips FUNERAL HOME

(b) Address Eldon, Mo.

19. (a) 2-3-44 (b) W. J. Allie
(Date received local registrar) (Registrar's signature)

Major findings: Of operations _____

Of autopsy _____

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 Kenneth Latham (M. D. or other) _____
Address California, Mo Date signed 2-3-44

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.....

Jacques D. Phillips....., Registered Apprentice No.....
working under my personal supervision.

Signed

Jacques D. Phillips

Licensed Embalmer No. *3663*

P. O. Address *Beacon*

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 148

Registration District No. 224

Primary Registration District No. 3046

1. PLACE OF DEATH:

(a) County Monterey California
(b) City or town California
(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 _____)
In this community _____ (Specify whether _____ years, months or days)

3. (a) PRINT FULL NAME

James Allie Williams

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

4. Sex F 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 Aug 10 (Month) (Day) (Year)

8. AGE: Years 60 Months 5 Days 12 (If less than one day) _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country) mo.

10. Usual occupation

11. Industry or business

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) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb Day 7 Year 1944 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 Cerebral hemorrhage Duration _____

Due to pneumonia ✓
Lobar - rt upper 7 days
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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature George J. Fatham (M. D. or other) M.D.
Address California, Ind Date signed 2-14-44

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SUPPLEMENTARY

FEB 10

3638