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7-5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

FILED APR 14 1944

Registration District No. 306

Primary Registration District No. 6128

Registrar's No. ....

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

1. PLACE OF DEATH:

(a) County Shannon

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

(c) Name of hospital or institution: Eminee 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 \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Shannon 101

(c) City or town Eminee Mo 1  
(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 Charles Ann Williams

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 22  
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.

4. Sex F

5. Color or race A

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

6. (b) Name of husband or wife Clinton Homer Williams

6. (c) Age of husband or wife if alive 49.8 years

7. Birth date of deceased June 26 1895  
(Month) (Day) (Year)

Immediate cause of death Coronary Occlusion

Due to Arterio Sclerosis

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

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

69 3 4 hr. \_\_\_\_\_ min.

Major findings: 94a

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation Wife

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

12. Name Williams Black

13. Birthplace Eminee Mo \_\_\_\_\_ (State or foreign country)

14. Maiden name Annida Whitwood

15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant Marie Perkins

(b) Address Amosa Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-24-44  
(Month) (Day) (Year)

(c) Place: burial or cremation Bethany Chapel

18. (a) Signature of funeral director J. B. Burns

(b) Address Mellow Spg. Mo

19. (a) 3-22-44 (Date received local registrar) (b) Frank Hyde (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 Frank Hyde (M. D. or other) \_\_\_\_\_

Address Eminee Date signed 3-22-44

RECEIVED

District Health Officer No. 5,

District File Number 444260

Date Filed 4-13-44

MAR 6 1950

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 T R Quinn

Licensed Embalmer No.....

P. O. Address Yellow Springs, 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.