. S. No. 2
DM—8-43
v. 5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 10 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 3763

Registration District No. 338 Primary Registration District No. 4501 Registrar's No.

1. PLACE OF DEATH:
(a) County Stoddard
(b) City or town Bloomfield (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 years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Stoddard
(c) City or town Bloomfield (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 Cara Williams
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Levi Williams
6. (c) Age of husband or wife if alive 72 years
7. Birth date of deceased Feb 12 1874 (Month) (Day) (Year)

8. AGE: Years 70 Months 9 Days 17 If less than one day hr. min.
9. Birthplace B. Idlewild (City, town, or county) Tenn (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
FATHER
12. Name John Aslin
13. Birthplace (City, town, or county) Tenn (State or foreign country)
MOTHER
14. Maiden name Eliza Jones
15. Birthplace (City, town, or county) Tenn (State or foreign country)
16. (a) Informant Levi Williams
(b) Address Bloomfield Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-1-44 (Month) (Day) (Year)
(c) Place: burial or cremation Lakeshore Cemetery
18. (a) Signature of funeral director Watkins Fred H
(b) Address Bloomfield
19. (a) 12/27/44 (Date received local registrar) (b) Pearl Elmore (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov 3 day 29 year 1944 hour 3 minute 15 P M.
21. I hereby certify that I attended the deceased from 9-20, 1944 to 11-25, 1944 that I last saw her alive on 11-25, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death CHRONIC MYOCADITIS
Due to ARTERIOSCLEROSIS
Due to
Other conditions HYPERTENSION (Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

Duration

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? (Specify type of place)
While at work? (e) Means of injury
23. Signature R. S. Davis (M. D. or other)
Address BLOOMFIELD Date signed 12-10-44

1130 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No 2,
District File Number 145-88
Date Filed 1-16-45

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 .....

Licensed Embalmer No. .....

P. O. Address .....

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.