No. 2
-8-43
-17-39
X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 19 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

3922 State File No.

Registration District No. 374 Primary Registration District No. 4549 Registrar's No.

1. PLACE OF DEATH:

(a) County Worth

(b) City or town Allendale Mo

(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 1 (Specify whether

In this community 7 yrs. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Worth 113

(c) City or town Allendale Mo 0

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

(d) Street No. 0

(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME BENJAMEN RILEY WILLIAMS.

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced Married 1

6. (b) Name of husband or wife Widow Adda Williams

6. (c) Age of husband or wife if alive 73 years

7. Birth date of deceased Sept. (Month) 12 (Day) 1867 (Year)

8. AGE: Years	Months	Days	If less than one day
77	2	20	hr. min.

9. Birthplace Lone Star Mo 0 (City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name J. Evan

13. Birthplace Unknown 0 (City, town, or county) (State or foreign country)

MOTHER 14. Maiden name Sarah Deane

15. Birthplace Unknown 0 (City, town, or county) (State or foreign country)

16. (a) Informant Adda Williams

(b) Address Allendale Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 6- 44 (Month) (Day) (Year)

(c) Place: burial or cremation Grant City Cemetary

18. (a) Signature of funeral director Arch C. Dunfee

(b) Address Grant City Mo.

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 2

year 1944 hour minute M.

21. I hereby certify that I attended the deceased from Instant death, 19; that I last saw h alive on, 19; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Coronary Thrombus	
Due to	
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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Arch C. Dunfee Jr. (M.D. or Other) Coroner

Address Date signed

1385 (Licensed Embalmer's Statement on Reverse Side)

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 Jack C. Dimple

Licensed Embalmer No. 3252

P. O. Address Grant City, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

S. No. 2B
M—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Feb

Registration District No. 374 Primary Registration District No. 4549 Registrar's No.

1. PLACE OF DEATH:

(a) County North
(b) City or town Glendale
(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 (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

3. (a) PRINT FULL NAME Benjamin R. Williams

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Sept (Month) 12 (Day) 1866 (Year)

8. AGE: Years 77 | Months 2 | Days 23 | If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

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

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

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec year 1944 hour minute M.

21. I hereby certify that I attended the deceased from ..., 19...; that I last saw h... alive on ..., 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

3922