

U. S. No. 2  
OM-5-43  
Rev. 5-17-39  
I X36671

State File No. ....

Registrar's No. ....

FILED SEP 1 1945  
Registration District No. 149

Primary Registration District No. 1002

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

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution:  
St Mary's Hosp. O.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 10 days 2 hrs 47 min.  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson 45

(c) City or town J.C.  
(If outside city or town limits, write "RURAL")

(d) Street No. 823 So. White Ave  
(If rural, give location)

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

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Judith Saalea Williams

3. (b) If veteran name war no 3. (c) Social Security No. none

4. Sex Female 5. Color or race W

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive 45 years

7. Birth date of deceased 8-11-45  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 21 year 1945 hour 8 minute 00 P.M.

21. I hereby certify that I attended the deceased from 8-11- to 8-21- 1945 that I last saw her alive on 8-21- 1945 and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
		<u>10</u>	<u>2</u> hr. <u>47</u> min.

Immediate cause of death congenital absence of Rectum Duration \_\_\_\_\_

Due to New born

9. Birthplace J.C. Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation New born

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

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

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

12. Name John Wilson Williams

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

14. Maiden name Laura Lucretia Blundell

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

Major findings: 157g

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

Of autopsy no

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs John Williams

(b) Address 4345 1/2 Lloyd

17. (a) Buried (b) Date thereof 8-23-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Woodlawn Cemetery

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? \_\_\_\_\_

18. (a) Signature of funeral director W. G. Carson, Funeral Home

(b) Address Independence Mo

19. (a) 8-22-45 (b) Theraldine Holmes  
(Date received local registrar) (Registrar's signature)

While at work \_\_\_\_\_ (Specify type of place)

(e) Means of injury \_\_\_\_\_

23. Signature R. Neighter, M.D. (M. D. or other)

Address Kansas City, Mo. Date signed 8/22/45

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**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 George F. Garrison  
Licensed Embalmer No. 2249  
P. O. Address Independence 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.**