

No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28224

FILED AUG 28 1945

State File No. _____

Registration District No. 280

Primary Registration District No. 4421

Registrar's No. 32

1. PLACE OF DEATH:

(a) County Platte

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

(c) Name of hospital or institution: 1

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 45 years (Specify whether years, months or days)

In this community 45 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Platten 8-5

(c) City or town Parkville 0
(If outside city or town limits, write "RURAL")

(d) Street No. 0
(If rural, give location) 0

(e) Citizen of foreign country? No (Yes or No) 0

If yes, name country _____

3. (a) PRINT FULL NAME Andrew Porter Williams

3. (b) If veteran, name war None

3. (c) Social Security No. 487-07-2021

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 12th year 1945 hour 4:00 minute P. M.

21. I hereby certify that I attended the deceased from January 8, 1945 to July 10, 1945

that I last saw him alive on July 10, 1945 and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race Col

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

6. (b) Name of husband or wife Emma Williams 6. (c) Age of husband or wife if alive 67 years

7. Birth date of deceased March 2, 1875
(Month) (Day) (Year)

Immediate cause of death Coronary Thrombosis Duration 3 days

Due to Arteriosclerosis No Facts

Due to _____

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

8. AGE: Years 70 Months 4 Days 10 If less than one day hr. min.

9. Birthplace Leavenworth County - Kansas
(City, town, or county) (State or foreign country)

10. Usual occupation Common Laborer

11. Industry or business _____

12. Name Martin Williams

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

14. Maiden name Ella

15. Birthplace Platte Cy Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Emma Williams

(b) Address Parkville, Missouri

17. (c) burial (b) Date thereof 7/16/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Muncie, Leavenworth, Kansas

18. (a) Signature of funeral director Hatkins Bros

(b) Address 1729 Lydia

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

Major findings: Of operations none

Of autopsy none

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 red.

23. Signature M. L. Holliday (M. D. or other) red.

Address Parkville Mo Date signed 7-14-45

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

Dr. Holliday

SEP 11 1948

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.....

J. Manlove

Licensed Embalmer No. *3994*

P. O. Address. *2503 Highland*

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.

Registration District No. 280

Primary Registration District No. 4421

1. PLACE OF DEATH:

(a) County Platte
(b) City or town Parkville
(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 _____ years, months or days

3. (a) PRINT FULL NAME Andrew P. Williams

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

4. Sex m 5. Color or race B 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 Mar 2 (Month) (Day) (Year)

8. AGE: Years 70 Months 4 Days 1 If less than one day _____ hr. _____ min.

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

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) _____ (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) Sept 5-45 (Date received local registrar) (b) Mrs. Clay Hiffer (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 _____ year 1945 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 _____

Duration _____

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? _____

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

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

S-28224