DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 14 1946

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 41723

Registration District No. 184 Primary Registration District No. 3038 Registrar's No. 612

1. PLACE OF DEATH:

(a) County Linn

(b) City or town Brookfield
(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 4 Month
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Linn 58

(c) City or town Brookfield 1
(If outside city or town limits, write "RURAL")

(d) Street No. 135 E. Clayton 2
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME MARTHA ELLA WILLIAMS

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

4. Sex F 5. Color or race Ch 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife John W. Williams 6. (c) Age of husband or wife if alive 71 years

7. Birth date of deceased Sept (Month) - 3 (Day) - 1878 (Year)

8. AGE: Years	Months	Days	If less than one day
67	3	5	hr. min.

9. Birthplace New Cambria Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Lewis Huffman
13. Birthplace Macon Co Mo
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Delila Summers
15. Birthplace Macon Co Mo
(City, town, or county) (State or foreign country)

16. (a) Informant John W. Williams
(b) Address Brookfield Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec-10-1945 (Month) (Day) (Year)
(c) Place: burial or cremation Dodson Cemetery

18. (a) Signature of funeral director Hill Funeral Home
(b) Address Brookfield Mo.

19. (a) 12-10-1945 (Date received local registrar) (b) Evelyn Kelley, Deputy (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 8
year 1945 hour 5 minute A M.

21. I hereby certify that I attended the deceased from Oct 20, 1945, to Dec 8, 1945; that I last saw her alive on Dec 6, 1945; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Inanition due to refusal to take food due to deranged mentality.	6 wks.
Due to	
Due to	
Other conditions Sciatica (Include pregnancy within 3 months of death)	3 mo.

Major findings:
Of operations ✓
Of autopsy ✓ 2000

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) no

(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 Mark H Rhoads (M. D. ~~or other~~)

Address Brookfield Mo. Date signed 12/10-45

1468 (Licensed Embalmer's Statement on Reverse Side)

PERMIT—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED
District Health Officer No
District File Number
Date Filed

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. H. Blackstock

Licensed Embalmer No. 2246

P.O. Address Brookfield M

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

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