

FILED DEC 29 1945

Registration District No. 297

Primary Registration District No. 3056

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

1. PLACE OF DEATH:

(a) County Randolph
(b) City or town Moberly
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution McCorum Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 8 days (Specify whether
In this community several years (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Monroe 69
(c) City or town Holley R.R. 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) 1
If yes, name country —

3. (a) PRINT FULL NAME William Monroe Timmons

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

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Ruth Elsie Boudo 6. (c) Age of husband or wife if alive 54 years

7. Birth date of deceased May 15 1887 (Month) (Day) (Year)

8. AGE: Years 58 Months 6 Days 3 If less than one day hr. min.

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

10. Usual occupation Farming

11. Industry or business Farming

12. Name William Joe Timmons

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

14. Maiden name Catherine Scott

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

16. (a) Informant Ruth Elsie Boudo

(b) Address Holley Mo R.R.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-20-1945 (Month) (Day) (Year)

(c) Place: burial or cremation St. Luke - Moberly

18. (a) Signature of funeral director Leta Thompson

(b) Address Madison Mo

19. (a) Nov. 20-45 (Date received local registrar) (b) Paul Williams (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 18 year 1945 hour 3 minute 45 a.m.

21. I hereby certify that I attended the deceased from Nov. 5, 1945, to Nov. 18, 1945; that I last saw him alive on Nov. 17, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death Intestinal obstruction Duration 7 days

Due to Probable cancer

Due to

Other conditions (Include pregnancy within 3 months of death)

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?

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

23. Signature W. R. Turner (M. D. or other) DO

Address Madison Mo Date signed 11/17/45

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 10

District File Number 12-45-1901

Date Filed DEC. 20-1945

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

Mrs. F. W. Thompson

Licensed Embalmer No.

3282

P. O. Address

Murphy, 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.

Registration District No. 294 Primary Registration District No. 3056

1. PLACE OF DEATH:

(a) County Randolph
(b) City or town Moberly
(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 William M. Timman

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 May 15 1948
(Month) (Day) (Year)

8. AGE: Years 58 Months _____ Days _____ If less than one day hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (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 Jan Day 8
year 1945 (hour) _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 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 Probably located at
Mis-seal junction
Due to _____

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

Major findings: Of operations _____ Of autopsy 469

ADDITIONAL
SUPPLEMENTARY
INFORMATION
REQUESTED

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 W. Turner (M. D. or other) _____
Date signed 1-4-46

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

SUPPLEMENTARY

42222

all (unclear) (unclear)

of
of R. Turner

~~of R. Turner~~