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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 25 1946

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 1944

Registration District No. 1

Primary Registration District No. 4001 5004

Registrar's No. 76

1. PLACE OF DEATH:

(a) County Adair

(b) City or town Novinger, "Rural" Nine Mile

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

(c) Name of hospital or institution: Daniels Mine

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

(d) Length of stay: In hospital or institution None (Specify whether

In this community Life

years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Adair

(c) City or town Novinger Rural

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

(d) Street No. R. R. No. 2

(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME William Albert Williams

3. (b) If veteran, name war

3. (c) Social Security No. 499-05-7072

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Minnie Viola Shoop

6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased Oct. (Month) 3 (Day) 1894 (Year)

8. AGE: Years 51 | Months 1 | Days 21 | If less than one day hr. min.

9. Birthplace Adair Co (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Miner

11. Industry or business Daniels Coal Mine

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

MOTHER
14. Maiden name Annie Cory
15. Birthplace Adair Co. (City, town, or county) Missouri (State or foreign country)

16. (a) Informant Mrs. Minnie Williams

(b) Address Novinger, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/25/45 (Month) (Day) (Year)

(c) Place: burial or cremation Novinger, Missouri

18. (a) Signature of funeral director D E Riley

(b) Address Kirksville, Missouri

19. (a) 12-10-45 (Date received local registrar) (b) Kate Lambert (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 24 year 1945 hour 9:00 minute A. M.

21. I hereby certify that I attended the deceased from , 19 , to , 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 Accidently Killed by falling rock in Daniels Mine, Novinger, Mo.	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
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 001

(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 Foster R. Easley Coroner (M. D. or other)

Address Bracheer, Mo. Date signed 11-24-45

(Licensed Embalmer's Statement on Reverse Side)

MAY 16 1946

RECEIVED
District Health Officer No. 10
District File Number 1-46-45
Date Filed JAN 23 1946

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 D E E Reling

Licensed Embalmer No. 4181

P. O. Address Kirkseville

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.

2B
45
43880

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. 1 Primary Registration District No. 5004 Registrar's No. 76

1. PLACE OF DEATH:

(a) County Adair

(b) City or town Rural - Nineveh Twp
(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 Life
years, months or days)

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 William A. 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 Oct (Month) 3 (Day) 9 (Year)

8. AGE: Years 51 Months 1 Days 21 If less than one day hr. min.

9. Birthplace (City, town, or county) Mo (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) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov 24
year 1945 hour minute M.

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

Immediate cause of death

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

174-8
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ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) accident

(b) Date of occurrence Nov. 24" 1945.

(c) Where did injury occur? Nonger (City or town) Adair (County) Mo (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
In Daniels Coal Mine
(Specify type of place)

While at work? Yes (e) Means of injury Falling Rock

23. Signature Foster R. Easley Coroner (M.D. or other)

Address Brashear, Mo Date signed 2-4-46

SUPPLEMENTARY

100029

1944