

No. 2-43
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 12 1946
Registration District No. 128

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

5321

State File No. _____
Registrar's No. 145

Primary Registration District No. 5465

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

1. PLACE OF DEATH:
(a) County Greene
(b) City or town Rural, N. Campbell Twp.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Rt. 4, Campbell Township
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community 3 yrs
years, months or days

3. (a) PRINT FULL NAME Wing Williams
3. (b) If veteran, name war None
3. (c) Social Security No. None

4. Sex Female 5. Color or race white
6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife UNK.
6. (c) Age of husband or wife Dec. 1865
7. Birth date of deceased March 30 1865
(Month) (Day) (Year)

8. AGE: Years 80 Months 10 Days 20
If less than one day hr. min.

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

10. Usual occupation Home Range

11. Industry or business _____

12. Name Wm. Anderson

13. Birthplace Don't know
(City, town, or county) (State or foreign country)

14. Maiden name Walter Chitties

15. Birthplace Don't know
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Nellie Kowatz

(b) Address Springfield Mo. Rural

17. (a) Burial (b) Date thereof Feb 12 46
(Burial, cremation, or other) (Month) (Day) (Year)

(c) Place: burial or cremation Union Chapel

18. (a) Signature of funeral director T. B. Chaffin

(b) Address Quart 219
19. (a) 2-12-46 (b) D. W. E. Handley
(Date received local register) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Greene
(c) City or town Rural, N. Campbell Twp. Spfd.
(If outside city or town limits, write "RURAL")
(d) Street No. Route #4
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Feb. day 10
year 1946 hour 1 minute 20
21. I hereby certify that I attended the deceased from Jan 2, 1945, to Feb 10, 1946
that I last saw him alive on Feb 10, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death
Heart Valvular Disease
& Bright's Disease

Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) _____

Major findings:
Of operations no
Of autopsy no
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: no
(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. F. Perry (M. D. or other) _____
Address 636 E. 3rd Springfield Mo. Date signed Feb 13 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 T. B. Chaffin

Licensed Embalmer No. 2192

P. O. Address Ozark, 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.

X

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. mar
Registrar's No. 145

Registration District No. 128 Primary Registration District No. 546 d

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Rural
(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 Vina Williams

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

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased Mar 20 (Month) (Day) (Year)

8. AGE: Years 80 Months 10 Days 10 If less than one day _____ hr. _____ min.

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

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) _____ (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 Mar Day 20 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 Chronic hepatitis years

Due to _____ 28 U.F. Ken

Due to _____

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

Major findings: Of operations _____

Of autopsy _____ 13/6

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 _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

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

4317 SUPPLEMENTARY

MENTARY

PROVISIONAL
SUPPLEMENTARY
CERTIFICATE OF DEATH
REQUESTED

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

5321