

8-43
5-17-39
1 X37823

DEPARTMENT OF COMMERCE BUREAU OF THE CENSUS
FILED JUL 9 1946 STANDARD CERTIFICATE OF DEATH

State File No. **20926**

Registration District No. **104** Primary Registration District No. **5711**

Registrar's No. _____

1. PLACE OF DEATH:
(a) County McDonald
(b) City or town Rural Elkhorn
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: None
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 57 yrs
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County McDonald
(c) City or town Rural Elkhorn
(If outside city or town limits, write "RURAL")
(d) Street No. Stella, Mo. R.F. 1-0
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Simeon Clark Williams
3. (b) If veteran, name war --
3. (c) Social Security No. --

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Feb. day 12
year 1946 hour 8 minute 20 p. M.

4. Sex Male 5. Color or race W
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Anna Williams
6. (c) Age of husband or wife if alive 65 years
7. Birth date of deceased November 5 1876
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Feb. 1 1946, to Feb. 12 1946
that I last saw him alive on Feb. 8 1946
and that death occurred on the date and hour stated above.
Immediate cause of death Carcinoma of Prostate and Bladder
Duration _____

8. AGE: Years 69 Months 3 Days 7
If less than one day _____ hr. _____ min.

Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____

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

10. Usual occupation Farming

11. Industry or business _____

MOTHER FATHER
12. Name James Williams
13. Birthplace Ill.
(City, town, or county) (State or foreign country)
14. Maiden name Saphrana St. John
15. Birthplace Missouri
(City, town, or county) (State or foreign country)

PHYSICIAN
Underline the cause to which death should be charged statistically.
518

16. (a) Informant John Williams
(b) Address Stella, Missouri

17. (a) Burial (b) Date thereof 2 17 46
(Burial, cremation, or removal) (Month) (Day) (Year)

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? _____

(c) Place: burial or cremation Tracy Cem. Anderson,
18. (a) Signature of funeral director W. M. Mann Pope
(b) Address Wheaton, Missouri
19. (a) 6-13-46 (b) O. E. Clumbert
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place) (c) Means of injury _____
23. Signature J. P. Edwards (M. D. or other) _____
Address Stella Date signed 2/10/46

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

RECEIVED

District Health Officer No.

District File Number 746-93

Date Filed 7-8-46

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 W. Morris Payne

Licensed Embalmer No. 3042

P. O. Address Wheaton, 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. July
Registrar's No. _____Registration District No. 194Primary Registration District No. 5741

1. PLACE OF DEATH:

(a) County McDonald
(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 _____ (Specify whether _____)
years, months or days3. (a) PRINT
FULL NAME Simon C. Wilkin

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 _____

7. Birth date of deceased mw 5
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
69 3 5 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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) _____

19. (a) 7/9/46 (b) O. C. Plunkett
(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 July 2
year 1946 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 _____

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) (c) Means of injury _____

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

Address _____ Date signed _____

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

SUPPLEMENTARY

20926