

S. No. 2
M-5-43
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 30899
Registrar's No. 9695

Registration District No. 187

Primary Registration District No. 3038

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

1. PLACE OF DEATH:
(a) County Deerfield
(b) City or town Brookfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: M. Farney Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME HOLMES EARL WILLIAMSON
(b) If veteran, name war _____ (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M
(b) Name of husband or wife Veloria Grace Williamson 6. (c) Age of husband or wife if alive 60 years
7. Birth date of deceased Jan-12-1880
(Month) (Day) (Year)

8. AGE: Years 66 Months 8 Days 6 If less than one day _____ hr. _____ min.

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

10. Usual occupation Burial Vault Mfg.

11. Industry or business _____

MOTHER FATHER
12. Name Dave Ross Williamson
13. Birthplace Portland Ind
(City, town, or county) (State or foreign country)
14. Maiden name Hannah M. Hordley
15. Birthplace D.K. Ind
(City, town, or county) (State or foreign country)

16. (a) Informant Hendrick A. Williamson
(b) Address 106 W. North St. Portland Ind.
17. (a) Removal (b) Date thereof Sept 18-1946
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Portland Ind

18. (a) Signature of funeral director Hill Funeral Home
(b) Address Brookfield Mo
19. (a) 9-19-46 (b) H. B. Ewin
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Indiana (b) County Jay 999
(c) City or town Portland 12
(If outside city or town limits, write "RURAL")
(d) Street No. 120 S. Pleasant 0
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 15
year 1946 hour 12 minute 40 P.M.
21. I hereby certify that I attended the deceased from Sept 17
1946, to Sept 18, 1946
that I last saw him alive on _____, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death Fracture of neck Duration 1 day

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) accident
(b) Date of occurrence Sept 17-1946
(c) Where did injury occur? Highway 26 Inland Jim Mo
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

23. Signature H. B. Ewin (M. D. or other) _____
Address Brookfield Date signed 9-15-46
While at work? _____ (Specify type of place)
(e) Means of injury automobile

Non-Collision

MAY 19 194E

30897

DISTRICT HEALTH OFFICE
Cameron, Mo.

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. Blacklocke
Licensed Embalmer No. 2246
P. O. Address Brookfield 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.