

Registration District No. 141

Primary Registration District No. 3025

1. PLACE OF DEATH:

(a) County Howell
(b) City or town West Plains
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Christa Hogan Hosp. 0
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Howell
(c) City or town West Plains
(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

Ruby Fay 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 Infant
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased 9 16 46
(Month) (Day) (Year)

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

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

10. Usual occupation _____

11. Industry or business Infant work

12. Name _____
13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name Leta Irene Williams

15. Birthplace Long Island, Kans
(City, town, or county) (State or foreign country)

16. (a) Informant P. F. Williams

(b) Address West Plains, Mo

17. (a) B (b) Date thereof 9-23-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation South Fork Mo

18. (a) Signature of funeral director Robertson

(b) Address West Plains, Mo

19. (a) Oct. 8, 1946 (b) Allys American
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 23
year 1946 hour 9 minute 30 A.M.

21. I hereby certify that I attended the deceased from 9/16, 1946 to 9/23, 1946
that I last saw h. ER alive on 9/23, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Premature ~~asixxx~~ Birth
Due to Traumatic fracture of pelvis and other injuries sustained accidentally by mother.

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

Major findings: Of operations 159
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 Robertson (M.D. or other) _____
Address West Plains, Missouri

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 5,

District File Number 1046564

Date Filed 10-17-46

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.....

Licensed Embalmer No.....

P. O. Address.....

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.