

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED JAN 28 1947**  
THE STATE BOARD OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

446

State File No. \_\_\_\_\_

Registration District No. 47

Primary Registration District No. 3008

Registrar's No. 34

14  
1  
2

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

1. PLACE OF DEATH:

(a) County Callaway

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

(c) Name of hospital or institution State Hospital no 1 2  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether years, months or days)

In this community 2 years 2 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Pulaski 14

(c) City or town Crocker  
(If outside city or town limits, write "RURAL") 5

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME CHARLIE WILLIAMS

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

4. Sex M 5. Color or race White

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

6. (b) Name of husband or wife Nellie Williams 6. (c) Age of husband or wife if alive 58 years

7. Birth date of deceased Nov 10 1896  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 22 year 1947 hour 8 minute 25 P M.

21. I hereby certify that I attended the deceased from Jan 19 1947 to Jan 22 1947 that I last saw him alive on Jan 22 1947 and that death occurred on the date and hour stated above.

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

50 2 12 hr. \_\_\_\_\_ min. \_\_\_\_\_

Immediate cause of death Pneumonia (terminal) Duration 3 days

Due to arteriosclerosis + myocarditis 3 yrs

Due to Syphilis 10 yrs

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

10. Usual occupation farmer

11. Industry or business rural

12. Name William Williams

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

14. Maiden name Lillie Stewart

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

Other conditions (Include pregnancy within 3 months of death)

Major findings: 309

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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

MOTHER FATHER

16. (a) Informant Records

(b) Address \_\_\_\_\_

17. (a) Removal (b) Date thereof 1-23-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Crocker, Mo

18. (a) Signature of funeral director Hallacy Funeral Home While at work? \_\_\_\_\_ (Specify type of place)

(b) Address 7 W 6th St. Fulton, Missouri (c). Means of injury \_\_\_\_\_

19. (a) 1-23-1947 (b) Joyce Monahan  
(Date received local registrar) (Registrar's signature)

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? 0

23. Signature Joyce Monahan (M. D. or other) M.D.  
Address State Hospital Date signed 1-22-47

RECEIVED  
District Health Officer No. 9,  
District File Number  
Date Filed JAN 27 1947

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 *Denzil C. Browning*  
Licensed Embalmer No. *2724*  
P. O. Address *Fulton 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.