

No. 2
-12-45
-17-39
X-27070

Registration District No. 383

Primary Registration District No. 3037

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

1. PLACE OF DEATH:

(a) County Lawrence

(b) City or town St. Vernon city

(c) Name of hospital or institution: Residence

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 (Specify whether)

In this community Native years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lawrence 55

(c) City or town St. Vernon (If outside city or town limits, write "RURAL") 3

(d) Street No. 337 (If rural, give location) 0

(e) Citizen of foreign country? No (Yes or No) 0

If yes, name country None

3. (a) PRINT FULL NAME Lucy Douglas Williamson

3. (b) If veteran, name war 7

3. (c) Social Security No. 2

4. Sex Female 5. Color or race white

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

6. (b) Name of husband or wife L

6. (c) Age of husband or wife if alive 4 years

7. Birth date of deceased 7-30-1860

(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>86</u>	<u>9</u>	<u>27</u>	hr. min.

9. Birthplace New Vienna Ohio

(City, town, or county) (State or foreign country)

10. Usual occupation not given

11. Industry or business

MOTHER FATHER

12. Name Acie Bailey

13. Birthplace New Jersey

(City, town, or county) (State or foreign country)

14. Maiden name Makala Gabe Rubin

15. Birthplace Ohio

(City, town, or county) (State or foreign country)

16. (a) Informant Mr. E. W. Whiteburg

(b) Address St. Vernon Mo.

17. (a) Burial (b) Date thereof 5-29-1947

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Quich Church

18. (a) Signature of funeral director Morris - Korman

(b) Address Miller Mo.

19. (a) 6-2-47 (b) ER Phelbrick

(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 27 year 1947 hour 9 minute 00 P.M.

21. I hereby certify that I attended the deceased from Feb. 18 1947 to May 27 1947; that I last saw her alive on May 27 1947 and that death occurred on the date and hour stated above.

Immediate cause of death acute endocarditis 10 days

Due to senile dementia 6 mot

Due to 92 E

Other conditions (Include pregnancy within 3 months of death)

Major findings: P. A. Halmer

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) (e) Means of injury Q

23. Signature P. A. Halmer (M. D. or other)

Address St. Vernon Mo. Date signed 6-3-47

RECEIVED

District Health Officer No. 6

District File Number 647-648

Date Filed JUN 10 1947

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11/11/47

11/11/47

11/11/47

11/11/47

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11/11

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

E. R. Leiman

Licensed Embalmer No. 3297

P. O. Address Miller 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.

Registration District No. 383

Primary Registration District No. 8037

1. PLACE OF DEATH:

(a) County Lamar
(b) City or town St. Verne
(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 Lucy D. 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 _____

7. Birth date of deceased: July 30 (Month) (Day) (Year)

8. AGE: 86 Years 9 Months 9 Days (If less than one day, hr., min.)

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

10. Usual occupation _____

11. Industry or business not given

MOTHER FATHER { 12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____ (State or foreign country)
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) Address _____

19. (a) _____ (b) CR Phillips (Data 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

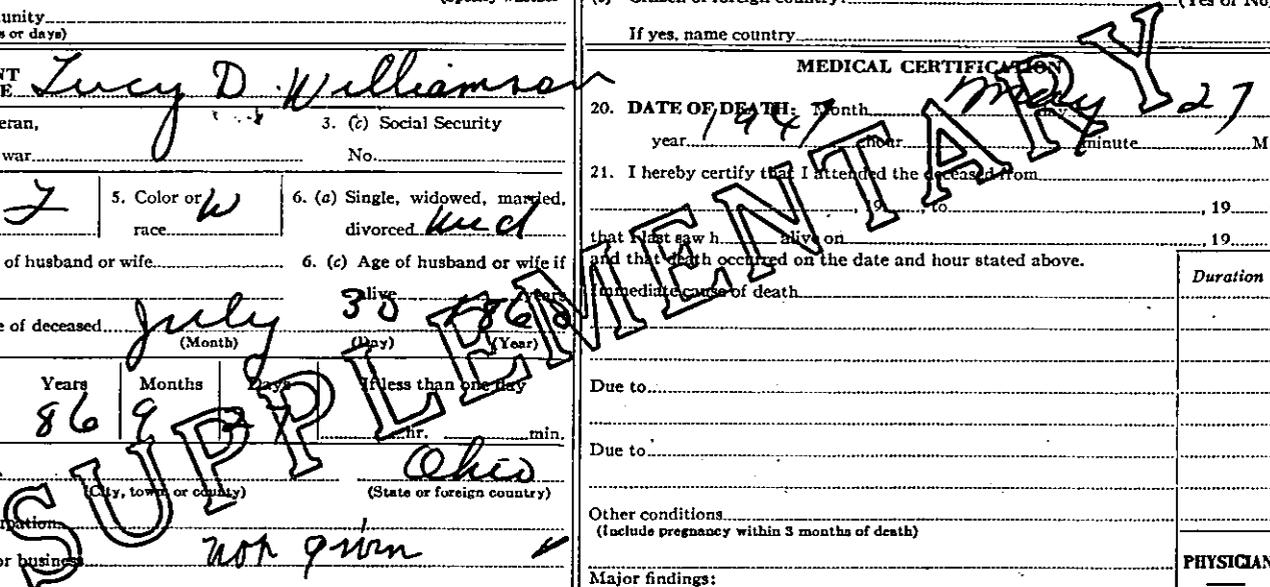
20. DATE OF DEATH: Month May Day 27 Year 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

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

Major findings: Of operations _____
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 _____ (M. D. or other) _____
Date signed _____



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

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

18026