S. No. 2
—11-10-39
v. 5-17-39
X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 40719

FILED DEC 2 1947

Registration District No. 3769 Primary Registration District No. 6225 Registrar's No. 175

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

1. PLACE OF DEATH:

(a) County Vernon

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

(c) Name of hospital or institution: State Hospital #3 2 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 mo. 3 days (Specify whether

In this community 3 Months 3 days years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Vernon 108

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

(d) Street No. 227½ W. Cherry (If rural, give location)

(e) If foreign born, how long in U. S. A.? ✓ years.

3. (a) PRINT FULL NAME ROBERT WILLIAMS

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife ✓

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

7. Birth date of deceased 8 (Month) 6 (Day) 1874 (Year)

8. AGE: Years 73 Months 3 Days 16 If less than one day hr. min.

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

10. Usual occupation None

11. Industry or business ✓

FATHER
12. Name T. J. Williams
13. Birthplace Pa. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Margaret Murphy
15. Birthplace Ohio (City, town, or county) (State or foreign country)

16. (a) Informant Hospital record

(b) Address Nevada, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-24-47 (Month) (Day) (Year)

(c) Place: burial or cremation Hospital Cemetery

18. (a) Signature of funeral director Allen V. Hays

(b) Address Nevada, Missouri

19. (a) 11-24-47 (Date received local registrar) (b) Kathryn Yancey (Registrar's signature) 221

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 22 year 1947 hour 3 minute — M.

21. I hereby certify that I attended the deceased from 8-19-47, 19 to 11-22-, 1947 that I last saw him alive on 11-21-, 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Arteriosclerosis	
Due to ✓	
Due to ✓	
Other conditions Hypertension (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? (Specify type of place)

While at work? (e) Means of injury

23. Signature R. G. Hall M.D. (M. D. or other)

Address Nevada Mo Date signed 11-22-47

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 7,
District File Number 44-47-1325
Date Filed 12-1-47

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was not embalmed ~~by me, or by~~ _____, Registered Apprentice No. _____, working under my personal supervision.

Signed H. L. Warmoduke

Licensed Embalmer No. 2070

P. O. Address Irwada, 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, above space should be left blank.