

No. 2
2-45
17-39
X-27970

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **41127**

FILED DEC 31 1947

Registration District No. **39**

Primary Registration District No. **4097**

Registrar's No. **189**

1. PLACE OF DEATH:

(a) County **Cass**
(b) City or town **Harrisonville**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Memorial Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ (Specify whether _____)
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Cass**
(c) City or town **Harrisonville**
(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 **FERN, ELAINE McWILLIAMS**

3. (b) If veteran, name war **✓** 3. (c) Social Security No. **✓**

4. Sex **Female** 5. Color of 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 **Dec 11 1947**
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days **15** If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name **W. E. McWilliams**

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

14. Maiden name **Bonnie McHarg**

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

16. (a) Informant **Warren E. McWilliams**

(b) Address **Harrisonville Mo.**

17. (a) **burial** (b) Date thereof **12-26-1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Crescent Hill Cemetery**

18. (a) Signature of funeral director **RUNNENBURGER'S**

(b) Address **HARRISONVILLE, MO.**

19. (a) **12-26-47** (b) **Laura J. Jones**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** day **26**
year **1947** hour **3:30** minute **A** M.

21. I hereby certify that I attended the deceased from **Dec 11**
_____ 19**47**, to **Dec 26** 19**47**;
that I last saw her alive on **Dec 25** 19**47**;
and that death occurred on the date and hour stated above.

Immediate cause of death
Terminal pneumonia
Malnutrition
Due to **Clot palate**
Absence of tongue
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) (c) Means of injury _____
23. Signature **O. H. Barger** (M. D. or other) _____
Address **Harrisonville Mo.** Date signed **12-26-47**

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAY 30 1947 PERMANENT RECORD

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.....

Infant Not Embalmed

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.