

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

7558

State File No.

FILED FEB 20 1947

Registration District No. 336

Primary Registration District No. 6137

Registrar's No.

1. PLACE OF DEATH:

(a) County Shannon

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

(c) Name of hospital or institution: No
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution No
(Specify whether years, months or days) 9 Years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Shannon 101

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

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

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

3. (a) PRINT FULL NAME Claudie Jo Ann Williams

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Child

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

7. Birth date of deceased Feb 11 1937
(Month) (Day) (Year)

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

9 11 18 hr. min.

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

10. Usual occupation

11. Industry or business

12. Name Robert Williams

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

14. Maiden name Ethel Williams

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

MOTHER FATHER

16. (a) Informant Mrs. Margret Orenard
(b) Address Teresita, Mo

17. (a) Burial (b) Date thereof Feb 2 47
(Burial, cremation, or removed) (Month) (Day) (Year)

(c) Place: burial or cremation Pilgrimage

18. (a) Signature of funeral director John F. Adelman
(b) Address Mountain view, Mo

19. (a) 7-7-47 (b) M. D. Orenard
(Date received local registrar) (Registrar's Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 29th
year 1947 hour 6 minute p M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h..... alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Due to Killed in Cyclone

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

Major findings:
.. Of operations _____
Of autopsy _____

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

22. If death was due to external causes, fill in the following: 101

(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 Frank B. de (M. D. or other) 3
Address _____ Date signed 1-30-47

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A 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 *John F. Duncan*
Licensed Embalmer No. *2516*
P. O. Address *Mountain View, 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.