

No. 2  
4-5-43  
5-17-39  
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THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 7560  
Registrar's No. \_\_\_\_\_

FILED FEB 20 1947

Registration District No. \_\_\_\_\_

Primary Registration District No. 6131

1. PLACE OF DEATH:

(a) County Shannon  
(b) City or town Teresitam- 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  
In this community 7 years, months or days) (Specify whether

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 Robert Jay Williams

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

4. Sex Male 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 June 4th 1939  
(Month) (Day) (Year)

8. AGE: Years 7 Months 7 Days 25 If less than one day 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)

16. (a) Informant Mrs. Margaret Orchard  
(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 Pilgrim Rest

18. (a) Signature of funeral director John J. Auman  
(b) Address Mountain View, MO

19. (a) 2/16/47 (b) Walter Rosen  
(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 him 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 \_\_\_\_\_  
187-8  
19

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 Frank Hyde (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ mo Date signed 1-30-47

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

MOTHER FATHER

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**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.....

*Joe B. Linneman*

Licensed Embalmer No. *4325*

P. O. Address.....

*Mountain View*

**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.**