

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MAY 13 1940

MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH

15512

Do not use this space.

1. PLACE OF DEATH

(a) County Monticau Registration District No. 571
 (b) Township Walden Primary Registration District No. 4335
 (c) City California (d) Street No. _____ St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 452 Ruth Williams St. ☐ (If nonresident, give city or town and State)
California Mo. 1
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 18-1888
 7. AGE YEARS 51 MONTHS 10 DAYS 25 If LESS than 1 day, _____ hrs. or _____ min.
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
 9. Industry or business in which work was done, as saw mill, bank, etc. none
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Monticau Co Mo

13. NAME John M Williams

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio

15. MAIDEN NAME Alice Gray Howard

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Cooper Co Mo

17. INFORMANT (ADDRESS) Francis Williams
California Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Masonic Home DATE 4/14

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Williams & Freidway
California Mo

20. FILED 4-15-1940 H.R. Popejoy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 12-1940

22. I HEREBY CERTIFY, That I attended deceased from Jan 20, 1940, to April 12, 1940
 I last saw h. alive on April 11, 1940 Death is said to have occurred on the date stated above, at 2 p.m.
 The principal cause of death and related causes of importance were as follows:

Spinal Sclerosis
+ Complete paralysis
chronic, progressive
Cause unknown
 Date of onset 30 yrs ago

Other contributory causes of importance:
Chronic spinal paralysis
+ sclerosis. 30 yrs duration
Cause unknown

Name of operation none Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?
 If so, specify L. L. Latham, M. D.
 (Signed) 504 (Address) California Mo

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.....

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.