

FILED MAR 19 1940

Registration District No. 653 Primary Registration District No. 6871

1. PLACE OF DEATH:
(a) County Pemissat Bragg
(b) City or town Deering
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community about 2 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME William P. Williams

3. (b) If veteran, name war No 3. (c) Social Security No. 91-16-0005

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Rendie Williams 6. (c) Age of husband or wife if alive 48 years

7. Birth date of deceased July 18, 1894
(Month) (Day) (Year)

8. AGE: Years 45 Months 6 Days 22 If less than one day hr. min.

9. Birthplace D.K. Alabama
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business W.P.A.

12. Name Peter Paul Williams

13. Birthplace D.K. Alabama
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth W. Fisher

15. Birthplace D.K. Alabama
(City, town, or county) (State or foreign country)

16. (a) Informant Rendie Williams

(b) Address Deering, Mo

17. (a) Burial (Burial, cremation, or removal) Burial (b) Date thereof 2/12/40
(Month) (Day) (Year)

(c) Place: burial or cremation Kennett Mo

18. (a) Signature of funeral director L. G. Wilson & Co

(b) Address Southville, Mo

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Pemissat
(c) City or town Deering
(If outside city or town limits, write "RURAL")
(d) Street No. 0 (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 11
year 1940 hour 3 minute 20 P. M.

21. I hereby certify that I attended the deceased from 2/2 1940 to 2/10 1940
that I last saw him alive on 2/10/40 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral apoplexy

Due to Hypertension

Due to g2d

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations none
Of autopsy none

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? g111 (Specify type of place) (e) Means of injury

23. Signature L. G. Wilson (M. D. or other)
Address 204 South Main St Date signed 2/25/40
Kennett, Mo.

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

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

MOTHER FATHER

APR 22 1942

PLSDC

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.....

Not Embalmed

....., 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 7640

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 653

Primary Registration District No. 6871

Registrar's No.

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

1. PLACE OF DEATH

(a) County Permiut
(b) City or town Braggadocia 9 P
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether

In this community _____
years, months or days)

3. (a) PRINT FULL NAME William P. Williams

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced mar

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 45 Months 6 Days 22 If less than one day _____ hr _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

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

14. Maiden name _____ (City, town, or county) (State or foreign country)

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

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 4/12/40 (b) L Pearl Kelly (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County Permiut

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

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

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

20. DATE OF DEATH Month Feb day 11 year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him _____ alive on _____ and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

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) (e) Means of injury _____

23. Signature L C Wilson (M. D. or other) _____

Address Kennett mo Date signed _____

MEDICAL CERTIFICATION

SUPPLEMENTAL

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

MAY 17 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. **7640**

Registration District No. **65-3**

Primary Registration District No. **6871**

Registrar's No.

1. PLACE OF DEATH:

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

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County
(c) City or town
(If outside city or town limits write "RURAL")
(d) Street No.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME **William P Williams**

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

4. Sex **m** 5. Color or race **w** 6. (a) Single, widowed, married, divorced **m**
6. (b) Name of husband or wife 6. (c) Age of husband, or wife, if alive years
7. Birth date of deceased **7** **19** **1899**
(Month) (Day) (Year)

8. AGE: Years **45** Months **6** Days **22** If less than one day
hr. min.

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

10. Usual occupation.....

11. Industry or business.....

12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) **7/12/40** (b) **Pearl Kelley**
(Date received local registrar) (Registrar's signature)

DEATH CERTIFICATION

20. DATE OF DEATH Month **Feb** day **11**
year hour minute M.

21. I hereby certify that I attended the deceased from 19..... to 19.....
that I have seen him alive on 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death.....

Due to.....

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) (e) Means of injury.....

23. Signature **L.C. Wilson** (M. D. or other).....

Address **Rennett** Date signed.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

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

MOTHER FATHER