

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

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.

Dep of 7640-48
State File No. 7644

Registration District No. 3 Primary Registration District No. 8-11 Registrar's No. _____

1. PLACE OF DEATH:
 (a) County Remick
 (b) City or town Rural, Deering, Mo.
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: None
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution None
(Specify whether years, months or days)
 In this community About 3 years

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo. (b) County Remick Co.
 (c) City or town Deering
(If outside city or town limits, write "RURAL")
 (d) Street No. 0 1/2
(If rural, give location)
 (e) If foreign born, born in U. S. A. _____ years.

3. (a) PRINT FULL NAME WILLIAM FLUMMER WILLIAMS

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Feb day 11
 year 1940 hour 3 minute 00 P. M.

3. (b) If veteran, name war None 3. (c) Social Security No. _____

21. I hereby certify that I attended the deceased from Feb 7-1940
 _____, 19____, to Feb 11, 1940
 that I last saw him alive on Feb 9-, 1940
 and that death occurred on the date and hour stated above.

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 1/2 years
 7. Birth date of deceased _____

Immediate cause of death	Duration
<u>cerebral hemorrhage</u>	<u>4 days</u>
Due to _____	_____
Due to <u>hypertension</u>	_____
Other conditions _____	_____
<small>(Include pregnancy within 3 months of death)</small>	

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

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

10. Usual occupation laborer

11. Industry or business W. P. A.

MOTHER FATHER
 12. Name Peter Williams
 13. Birthplace Hamilton Alabama
(City, town, or county) (State or foreign country)

14. Maiden name Mrs. Sabetha Nichols
 15. Birthplace Hamlet Ala.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature J. P. Angle
 (b) Address Remick, Mo.

17. (a) Burial (b) Date thereof Feb-12-1940
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Remick, Mo.

18. (a) Signature of funeral director None
 (b) Address Deering neighborhood

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

PHYSICIAN
 Major findings: _____
 Of operations _____
 Of autopsy _____
Underline the cause to which death should be charged statistically.

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

23. Signature L. C. Wilson (M. D. or other) _____
 Address Remick, Mo. Date signed 2-12-40

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No.

7640
7644

Registration District No. 653

Primary Registration District No. 5871

Registrar's No.

1. PLACE OF DEATH:

(a) County Pemiscot
(b) City or town Brazzardocia
(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)

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

Wm Plummer William

(b) If veteran, name war.....

(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..... 18

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

19..... 18
(Year)

8. AGE:

Years	Months	Days	If less than one day
<u>45</u>	<u>6</u>	<u>22</u>	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) 4/12/48 (b) Pearl Kelley
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Feb day 11
year 1940 hour..... minute..... 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.....

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 H. C. Wilson (M. D. or other).....

Address Hennett res Date signed.....

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER