

1940 APR 1 1940

11920

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 657

Primary Registration District No. 4388

Registrar's No. 16

1. PLACE OF DEATH:

(a) County Christian

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

(c) Name of hospital or institution:
Country Club Jail
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3
(Specify whether _____)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Christian

(c) City or town "Rural" Little Prairie
(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.

3. (a) PRINT FULL NAME WALTER WILLIAMS 452

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

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

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

7. Birth date of deceased. not known
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 15th day Jan year 1940 hour 1 minute 50 P. M.

21. I hereby certify that I attended the deceased from 1/15 1940 to 1/15 1940 that I last saw him alive on 1/15 1940 and that death occurred on the date and hour stated above.

8. AGE: Years about 40 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace not known
(City, town, or county) (State or foreign country)

Immediate cause of death acute alcoholism

Due to _____

Due to 95%

Other conditions (include pregnancy within 3 months of death) _____

10. Usual occupation _____

11. Industry or business _____

12. Name not known

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

14. Maiden name not known

15. Birthplace not known
(City, town, or county) (State or foreign country)

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

Major findings:
Of operations _____

Of autopsy _____

16. (a) Informant's own signature Wesley Randolph

(b) Address _____

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

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

17. (a) Burial (b) Date thereof JAN- 12- 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Country farm

18. (a) Signature of funeral director Wesley Randolph

(b) Address Co. Farm, Cmn. CO.

19. (a) not known (b) not known
(Date received local registrar) (Registrar's signature)

(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? _____

545 (Specify type of place) _____
While at work? _____ Means of injury _____

23. Signature Geo. Whipp (M. D. or other) _____
Address Caruthersville, Mo Date signed 1/19/40

Feb. 9 - 1940 Ada M... (Licensed Embalmer's Statement on Reverse Side)

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

Rev. 5-17-39
Do not write

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.

3-40-21

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.

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BUREAU OF THE CENSUS

Registration District No. 657

Primary Registration District No. 4388

Registrar's No.

1. PLACE OF DEATH:

(a) County Remiseot
(b) City or town Canthersville mo
(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

Walter Williams

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex m

5. Color or race col

6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife _____

6. (c) Age of husband, or wife, if alive _____ years

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

8. AGE: Years Months Days If less than one day
About 40 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 _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) May 9, 1940 (b) Ada Martin (Registrar's signature)

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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 15 day Jan
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____;
that I last saw h_____ 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) (a) Means of injury _____

23. Signature G. W. Phipp (M. D. or other)

Address Canthersville Date Jan 15, 1940

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTAL

11920 (1940)