

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 28659

Registration District No. 384

Primary Registration District No. 4227

Registrar's No. 1

1. PLACE OF DEATH:

(a) County Hawes  
(b) City or town West Plains, Mo  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Laura Sheppard Home  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 day  
(Specify whether  
In this community 5 months (Specify whether  
years, months or days)

8. (a) PRINT FULL NAME Peggy Sue Williams

3. (b) If veteran,  name war. 8. (c) Social Security No. 2

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

6. (b) Name of husband or wife ✓ 6. (c) Age of husband or wife if alive 2 years

7. Birth date of deceased 2/12-1940  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
5 6 hr. min.

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

10. Usual occupation Infant

11. Industry or business 4

12. Name Paul Williams

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

14. Maiden name Paul Williams

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

16. (a) Informant Paul Williams

(b) Address Maady, Mo

17. (a) Burial (b) Date thereof 8/19-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Maady

18. (a) Signature of funeral director Roberts

(b) Address West Plains, Mo

19. (a) 8-27-40 (b) Vida W SIMONS  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri County Hawes  
(c) City or town West Plains, Mo  
(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 8 day 18  
year 1940 hour 8 minutes 06 P. M.

21. I hereby certify that I attended the deceased from 8/18  
1940, to 8/18, 1940

that I last saw h. alive on 8/18/40, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Euteritis 11/18 4 days

Due to Dean

Other conditions  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations  
Of autopsy

Duration  
4 days  
PHYSICIAN  
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?

344 While at work? (Specify type of place) (e) Means of injury

23. Signature Maury Thompson (M. D. or other) M.D.

Address West Plains Date signed

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

M. Thompson

RECEIVED

District Health Officer No. 5,

District File Number 940908

Date Filed \_\_\_\_\_

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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 \_\_\_\_\_

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.**