

Registration District No. 321Primary Registration District No. 4553

State File No. _____

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Scott**
 (b) City or town **Sikeston**
 (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 **Joe N. Williams**

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

4. Sex **Male** 5. Color or race **Col.** 6. (a) Single, widowed, married, divorced **Single**
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **Nov. 19 1939**
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
1 9 13 hr. min.

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

10. Usual occupation **Infant**

11. Industry or business _____

MOTHER FATHER { 12. Name **Henry Williams**
 13. Birthplace **Arkansas**
 (City, town, or county) (State or foreign country)
 14. Maiden name **Mabel Watson**
 15. Birthplace **Pemiscot County Missouri**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Mabel Williams**
 (b) Address **Sikeston, Mo.**

17. (a) **Burial** (b) Date thereof **9 - 3 - 41**
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Sikeston, Missouri**

18. (a) Signature of funeral director **H. Welch**
 (b) Address **Sikeston, Missouri**

19. (a) **9-11-41** (b) **W. W. Prussia**
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Scott**
 (c) City or town **Sikeston, Missouri**
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept.** day **2**
 year **1941** hour **8** minute **15** A: M.

21. I hereby certify that I attended the deceased from **8-24-41**
 to **9-2-41**, 19**41**,
 that I last saw him alive on **9-2-41**, 19**41**,
 and that death occurred on the date and hour stated above.

Immediate cause of death **Acute Bronchitis**
Pneumonia
 Due to _____
 Due to _____

Other conditions (Include pregnancy within 3 months of death)
 Major findings:
 Of operations _____
 Of autopsy **None**

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

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

(a) Accident, suicide, or homicide (specify) **None**
 (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 **W. W. Prussia** (M. D. or other)
 Address **Sikeston** Date signed **9-11-41**

RECEIVED

District Health Office No. 2,

District File Number 941-138

Date Filed 9/13/41

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.....

H. J. Welsh

Licensed Embalmer No. 774

P. O. Address. Sikeston, Missouri

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, fact should be so stated above.

M

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 29538

Registration District No. 821

Primary Registration District No. 4553

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Scott
(b) City or town Sikeston
(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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Joe N. Williams

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

4. Sex M 5. Color or race B 6. (a) Single, widowed, married, divorced 2

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

7. Birth date of deceased Nov 29, 1939
(Month) (Day) (Year)

8. AGE: Years 1 Months 9 Days 2 (If less than one day _____ min.)

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

10. Usual occupation _____

11. Industry of 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) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept Day _____
year 1941 hour _____ minute _____ M.

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

that I last saw him/her alive on _____ 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to Acute Colitis unnummed 5 days
Bacillary Dysentery 2 weeks

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

Duration

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? _____

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

23. Signature R. C. Conrad (M. D. or other) M.D.

Address _____ Date signed _____

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

Portagville mo

SUPPLEMENTARY

