

1. PLACE OF DEATH:

Cape Girardeau
(a) County
(b) City or town Jackson 11A1M
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 78 years (Specify whether years, months or days)
In this community _____

2. USUAL RESIDENCE OF DECEASED:

Missouri Cape Girardeau
(a) State (b) County
(c) City or town Jackson Mo. 16
(If outside city or town limits, write "RURAL") 2
(d) Street No. _____ (If rural, give location) 1
(e) Citizen of foreign country? _____ (Yes or No) No
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11-2- day 2
year 41 hour 7:00 minute AM
21. I hereby certify that I attended the deceased from 2-
5 1941 to 11-2- 1941
that I last saw her alive on 10-22- 1941
and that death occurred on the date and hour stated above.

Immediate cause of death
Senile Encephalitis
Due to 1. Senility
2. Myocarditis
3. Anemia
Other conditions (Include pregnancy within 3 months of death)

Duration

PHYSICIAN

Major findings:
Of operations 1628
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?
While at work _____ (Specify type of place) _____ (e) Means of injury ✓
23. Signature Alfred M. Eaton (M. D. or other) M.D.
Address Jackson Mo. Date signed 11-3-41

3. (a) PRINT FULL NAME Mary C Williams

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

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

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

7. Birth date of deceased December 29 1862
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>78</u>	<u>10</u>	<u>3</u>	_____ hr. _____ min.

9. Birthplace Jackson Mo. 11
(City, town, or county) (State or foreign country)
Housewife

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name Dr. David T Pace
13. Birthplace Kentucky
(City, town, or county) (State or foreign country)
14. Maiden name Sarah Ann Criddle
Virginia Virginia
15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant Frank W. Brooking
(b) Address Jackson, Mo.

17. (a) Burial (b) Date thereof 11 4 1941
(Burial, cremation, or removal) (Month) (Day) (Year)
Jackson Mo. City Cem.
(c) Place: burial or cremation.

18. (a) Signature of funeral director William Staller Seebach
(b) Address Jackson Mo.

19. (a) 11-4-41 (b) B. S. Schubert
(Date received local registrar) (Registrar's signature)

DEC 16 1949

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 Glenn Wilson
Licensed Embalmer No. 2828
P. O. Address Jackson Mo.

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.