

No. 2
4-13-40
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 16 1942
Registration District No. 607

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

3022

State File No. _____
Registrar's No. 7

Primary Registration District No. 4361

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

1. PLACE OF DEATH:
(a) County New Madrid
(b) City or town New Madrid
(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 17 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County New Madrid
(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.?

3. (a) PRINT FULL NAME Jack Williams
3. (b) If veteran name was
3. (c) Social Security No.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 1 day 19
Year 1942 hour 12 minute 30 A. M.

4. Sex M race W
6. (b) Name of husband or wife None
7. Birth date of deceased None Sept - 16 - 1891 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan 9 1942 to Jan 19 1942 that I last saw him alive on Jan 16 1942 and that death occurred on the date and hour stated above.

8. AGE: Years 100 Months 7 Days 3 If less than one day hr. min.
9. Birthplace Ala. Ala. (City, town, or county) (State or foreign country)

Immediate cause of death: Uremia
Due to: Prostatic hypertrophy? years
Due to: Old Age

10. Usual occupation
11. Industry or business Labour
12. Name Peter Williams
13. Birthplace
14. Maiden name
15. Birthplace

Other conditions: none
(Include pregnancy within 3 months of death)
Major findings: none
Of operations: none
Of autopsy: none
PHYSICIAN

16. (a) Informant Bessie Thomas
(b) Address 1015 E Morgan St
17. (a) Burial (b) Date thereof 1-19-42 (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) Jan 27 1942 (b) Registrar's signature

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) While at work (e) Means of injury
23. Signature J. B. Conrad (M. D. or other) M.D.
Address Postaville, Mo Date signed 1-20-42

RECEIVED

District Health Office No. 2,

District File Number 2-42-18

Date Filed 2-10-42

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.....

Not Embalmed

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, fact should be so stated above.