

FILED MAY 18 1944

Registration District No.

Primary Registration District No. 5820

Registrar's No. 14

1. PLACE OF DEATH:

(a) County New Madrid

(b) City or town Gideon "rural"
(If outside city or town limits, write "RURAL" and name of the ship)

(c) Name of hospital or institution: Anderson Hosp
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution.....
In this community 5 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County New Madrid

(c) City or town Gideon
(If outside city or town limits, write "RURAL")

(d) Street No. 4 mi. N.E. Gideon
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Robert Christopher Williams

3. (b) If veteran, name war no

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 22
year 1944 hour 3 minute 30 A.M.

21. I hereby certify that I attended the deceased from April 19-44
1944 to April 22 1944

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

6. (b) Name of husband or wife Minnie 6. (c) Age of husband or wife if alive 69 years

7. Birth date of deceased July 13 1862
(Month) (Day) (Year)

that I last saw him alive on April 11 1944
and that death occurred on the date and hour stated above.

Immediate cause of death apoplexy Duration

8. AGE: Years 81 Months 9 Days 9 If less than one day
hr. min.

Due to Cerebral Hemorrhage

Due to J 20!

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

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy none

10. Usual occupation farming

11. Industry or business "

PHYSICIAN

Underline the cause to which death should be charged statistically.

MOTHER FATHER

12. Name Alice Williams

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

14. Maiden name Mahan

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

16. (a) Informant MINNIE WILLIAMS

(b) Address R-1 GIDEON

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

(a) Accident, suicide, or homicide (specify) no

(b) Date of occurrence April 22 1944

17. (a) Burial (b) Date thereof Apr 23 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Where did injury occur? 2nd Street 2nd
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
none

(c) Place: burial or cremation Starfield Cemetery

(Specify type of place)

While at work? no (e) Means of injury no

18. (a) Signature of funeral director J. Schumann

(b) Address Malden Mo

23. Signature R. E. Beal (M. D. or other)

19. (a) 5-1-44 (b) Zende Macom
(Date received local registrar) (Registrar's signature)

Address Gideon Mo Date signed Apr 22 1944

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

200

RECEIVED

District Health Office No. 2,

District File Number 544-743

Date Filed 5-15-44

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 J. J. Johnson
Licensed Embalmer No. 4086
P. O. Address Malden

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.