

S. No. 2
M-8-43
7-5-17-39
X37823

2308

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED JAN 19 1948

Registration District No. 217

Primary Registration District No. 3045

Registrar's No. 93

1. PLACE OF DEATH:
(a) County Mississippi
(b) City or town Charleston
(c) Name of hospital or institution:
South Elm St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community All Of Life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Miss.
(c) City or town Charleston
(If outside city or town limits, write "RURAL")
(d) Street No. South Elm St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country. None

3. (a) PRINT FULL NAME Sylas Williams

MEDICAL CERTIFICATION
20. DATE OF DEATH, Month December day 16th
year 1944 hour 7 minute 38 P. M.

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

21. I hereby certify that I attended the deceased from 11-30- 1944 to 12-14 1944
that I last saw him alive on 12-14- 1944
and that death occurred on the date and hour stated above.

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

Immediate cause of death Robert Pneumonia

6. (b) Name of husband or wife Lucy Williams (dec'd) 6. (c) Age of husband or wife if alive 1841 years

Due to Influenza

7. Birth date of deceased November 20th 1841
(Month) (Day) (Year)

Due to _____

8. AGE:	Years	Months	Days	If less than one day
	<u>103</u>	<u>0</u>	<u>26</u>	hr. _____ min.

Other conditions (Include pregnancy within 3 months of death) 3 1/2

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

Major findings:
Of operations _____
Of autopsy _____

10. Usual occupation Retired

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____

11. Industry or business Farmer (Ex-Slave)

(c) Where did injury occur? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Mo.

12. Name John Williams

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

13. Birthplace N.K. Ky.
(City, town, or county) (State or foreign country)

23. Signature W. A. Fungal (M. D. or other) _____
Address 204 S. Locust St. Charleston Mo. Date signed 12-19-44

14. Maiden name Ann Williams

15. Birthplace N.K. Maryland
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Mary Hawkins
(b) Address Charleston, Mo.

17. (a) (Burial, cremation, or removal) Burial (b) Date thereof 12-20-44
(Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Charleston, Mo.
18. (a) Signature of funeral director John I. Nemmel
(b) Address Charleston, Mo.
19. (a) Signature Jan 5 1948 (b) Mrs. Tom Moore
(Date received local registrar) (Registrar's signature)

Duration 9 days
2 wks
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

1231

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Office No. 2,

District File Number 145-98

Date Filed 1-16-45

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 John F. Minnielee Jr
Licensed Embalmer No. 3851
P. O. Address Charleston, 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.