

No. 2
M-5-43
5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
UNITED STATES GOVERNMENT
FEDERAL BUREAU OF INVESTIGATION
STANDARD CERTIFICATE OF DEATH

State File No. **23579**
Registrar's No. **187**

Registration District No. **43**
Primary Registration District No. **3007**

1. PLACE OF DEATH:
(a) County **Butler**
(b) City or town **Poplar Bluff**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Brandon Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **4 days**
In this community **Thirty Years**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **Roland Woodard Williams**
3. (b) If veteran, name war _____
3. (c) Social Security No. **no**

4. Sex **M** Color or race **W**
5. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **8 31 1873**
(Month) (Day) (Year)

8. AGE: Years **72** Months _____ Days **26**
If less than one day _____ hr. _____ min.

9. Birthplace **Hunington Tenn**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business _____

MOTHER FATHER {
12. Name **D. K**
13. Birthplace **D K** **9**
(City, town, or county) (State or foreign country)
14. Maiden name **D K**
15. Birthplace **D K** **9**
(City, town, or county) (State or foreign country)

16. (a) Informant **Bernice Williams**
(b) Address **153 Cedar Ave Memphis Tenn**

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Oak Ridge Cem Kennett Mo**

18. (a) Signature of funeral director **Lentz Und Co**
(b) Address **Kennett Mo**

19. (a) **7-11-45** (b) **Belle Turner**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo** (b) County **Dunklin 35**
(c) City or town **Kennett 2**
(If outside city or town limits, write "RURAL")
(d) Street No. **202 Kennett 2**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **7** day **5**
year **1945** hour **6 am** minute **10** M.
21. I hereby certify that I attended the deceased from **June 30**, 19**45**, to **July 5**, 19**45**.
that I last saw him alive on **July 5**, 19**45**,
and that death occurred on the date and hour stated above.

Immediate cause of death **Endocarditis** **6-30-45**
Due to **Nephritis** **4-30-45**
Duration
Other conditions _____
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings:
Of operations _____
Of autopsy _____
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
Underline 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 **[Signature]** (M. D. or other) _____
Address **Poplar Bluff Mo** Date signed **7-10-45**

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

RECEIVED

District Health Office No. 2

District File Number 745-976

Date Filed 7-23-45

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

Walter A. Heubers

Licensed Embalmer No.

2002

P. O. Address

Kennett me

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 43

Primary Registration District No. 3007

Registrar's No. 187

1. PLACE OF DEATH:

(a) County Butler

(b) City or town Caplan Kleff
(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 years, months or days)

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 Roland Woodard Williams

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____
year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 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)

4. Sex _____

5. Color or race _____

6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____

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

7. Birth date of deceased _____
(Month) (Day) (Year)

Duration _____

Due to _____

Due to _____

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

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

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

Major findings:
Of operations _____

Of autopsy _____

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

10. Usual occupation _____

11. Industry or 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)

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)

(b) 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 _____

Signature _____ (M. D. or other) _____

Address _____ Date signed _____

16. (a) Informant _____

(b) Address _____

17. (a) Burial (b) Date thereof 7-8-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director Lutz Funeral Home

(b) Address Kennett Mo

19. (a) 7-18-45 (b) Walter Turner
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

SUPPLEMENTARY

23579

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. A49Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 187

1. PLACE OF DEATH:

(a) County Butler
 (b) City or town Poplar Bluff
 (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 Roland W. Williams

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

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

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

7. Birth date of deceased 4-9-31
(Month) (Day) (Year)8. AGE: Years 72 Months _____ Days _____ If less than one day _____ hr. _____ min.9. Birthplace Tenn
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or 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)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July
year 1942 hour _____ minute _____ M.21. I hereby certify that I attended the deceased from _____, 19____
to _____, 19____

that I last saw him _____ alive on _____, 19____

and that death occurred on the date and hour stated above.

Immediate cause of death _____

Duration _____

Due to _____

Due to chronic nephritisOther conditions _____
(Include pregnancy within 3 months of death)Major findings: Of operation 315

Of autopsy _____

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 time of place)
(? Means of injury)23. Signature W. J. Sawyer (M. D. or other) _____Address _____ Date signed 7-28-45

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

SUPPLEMENTARY

ADDITIONAL
SUPPLEMENTARY
INFORMATION
REQUESTED

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

23579