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5-17-39
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FILED **DEC 33 1945**

Registration District No. **333**

Primary Registration District No. **3074**

Registrar's No. **39**

1. PLACE OF DEATH:
(a) County Scott
(b) City or town Likeston Sunset Add.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 209 Alabama St - Home 1
(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: Pauline Williams
3. (b) If veteran, name war _____ **3. (c) Social Security** No. _____

4. Sex: F 3 **5. Color or race:** Col **6. (a) Single, widowed, married, divorced, infant:** infant
6. (b) Name of husband or wife: _____ **6. (c) Age of husband or wife if alive:** _____ years
7. Birth date of deceased: 11 10 1945
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day 6 hr. _____ min.

9. Birthplace: Likeston - Sunset Add. Mo
(City, town, or county) (State or foreign country)

10. Usual occupation: _____
11. Industry or business: Farming

12. Name: Johnnie Williams
13. Birthplace: Osannon Mississippi
(City, town, or county) (State or foreign country)
14. Maiden name: Margaret Hardy
15. Birthplace: West Point Arkansas
(City, town, or county) (State or foreign country)

16. (a) Informant: Johnnie Williams
(b) Address: 209 Alabama St. Sunset Add. - Likeston

17. (a) (b) Date thereof: _____ (Month) (Day) (Year)
(c) Place: burial or cremation: Sunset Cemetery 11-12-45

18. (a) Signature of funeral director: Johnnie Williams
(b) Address: 209 Alabama St

19. (a) (b) Registrar's signature: Mrs. F. F. Henry
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Scott
(c) City or town Likeston - Sunset Addition
(If outside city or town limits, write "RURAL")
(d) Street No. 209 Alabama St
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 11 day 11 year 1945 hour 8 minute 7 M.
21. I hereby certify that I attended the deceased from 11-10, 1945, to 11-11, 1945;
and that death occurred on the date and hour stated above.

that I last saw him alive on 11-11, 1945;
Immediate cause of death: Premature Born Duration _____
Due to Malnutrition
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy 159
PHYSICIAN _____
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)
(c) Means of injury _____
23. Signature: Appie Deary
Address Likeston, Mo. Sunset Add. Date signed 11-12-45

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

MOTHER FATHER

RECEIVED

District Health Office No. 2,

District File Number 1145-3312

Date Filed 11-30-45

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.....

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.

Registration District No. 333

Primary Registration District No. 3074

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

1. PLACE OF DEATH:

(a) County Scott

(b) City or town Sheldon
(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 Pauline Williams

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

4. Sex F 5. Color or race B 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 Nov. 10 (Month) (Day) (Year)

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

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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 _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 11-25-45 (b) Mrs G F Henry (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 _____ Year 1946 Hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 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 _____

Duration

Due to _____

Due to _____

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.

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 Dattis Seal - midwife addition _____ (City, town, or county) (State) _____

Signature Mrs G F Henry _____ Date signed 11-25-45 _____ (Registrar's signature)



