

No. 2  
4-41  
17-39  
X29484

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

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS  
FILED FEB 13 1948

Sargent

Registration District No. \_\_\_\_\_

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

3662

State File No. \_\_\_\_\_

Primary Registration District No. 3074

Registrar's No. 22

1. PLACE OF DEATH:

(a) County Scott

(b) City or town Sikeston  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Sikeston General Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 9 years  
(Specify whether years, months or days)

In this community 9 years  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County New Madrid

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

(d) Street No. \_\_\_\_\_  
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Lewis H. Williams

3. (b) If veteran, name war no

3. (c) Social Security No. 491-26-4260

4. Sex M ( ) 5. Color or race W

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

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased 3 31 1889  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	57	9	6	hr. _____ min.

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

10. Usual occupation Farm Labor

11. Industry or business \_\_\_\_\_

12. Name Alec Williams

13. Birthplace Atlanta, Ga.  
(City, town, or county) (State or foreign country)

14. Maiden name Missouri Coffey

15. Birthplace Atlanta, Ga.  
(City, town, or county) (State or foreign country)

16. (a) Informant Calvin Williams

(b) Address Farma, Mo.

17. (a) Burial (b) Date thereof 1/10/48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Matthews, Mo.

18. (a) Signature of funeral director H. W. Albritton

(b) Address Sikeston, Mo.

19. (a) 2-5-48 (b) Mrs. D. Henry  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 7  
year 1948 hour 12 minute 30 pm.

21. I hereby certify that I attended the deceased from 11-19 1947 to 1-7-48, 1948  
that I last saw him alive on 1-7-48  
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac failure  
Duration \_\_\_\_\_

Due to Cardiac decompensation

Due to Asthma

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? 0

While at work? \_\_\_\_\_  
Means of injury \_\_\_\_\_

23. Signature Alden P. Sargent (M. D. or other) MD  
Address Sikeston, Mo. Date signed 1-26-48

MAR 5 1948

RECEIVED  
District Health Office No. 2,  
District File Number 248-198  
Date Filed 2-9-48

MAR 5 1948

**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.

HEALTH CO.

Signed John Allerton  
Licensed Embalmer No. 21941  
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.