

No. 2  
5-43  
5-17-39  
K36671

FILED MAR 9 1948

Registration District No. 2-10

Primary Registration District No. 5827

Registrar's No. 7

1. PLACE OF DEATH:

(a) County New Madrid

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

(c) Name of hospital or institution:  
1 mile east of Catron  
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County New Madrid 72

(c) City or town Rural 0  
(If outside city or town limits, write "RURAL")

(d) Street No. 1 mile east of Catron 0  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME George Harrison Williams

3. (b) If veteran, name war No.

3. (c) Social Security No. None.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 19  
year 1948 hour 8 minute 20 P.M.

21. I hereby certify that I attended the deceased from 2-19  
1948, to 2-19 1948

that I last saw him alive on 2-19  
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White

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

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

7. Birth date of deceased December 26 1947  
(Month) (Day) (Year)

Immediate cause of death Labor Pneumonia

Duration 1 week

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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

23 hr. min.

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: 108

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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

10. Usual occupation Infant

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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

12. Name Aubry Williams

13. Birthplace Trenton, Tennessee  
(City, town, or county) (State or foreign country)

14. Maiden name Agnes Sparks

15. Birthplace Arkansas  
(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)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

16. (a) Informant Aubry Williams

(b) Address Lilbourn, Missouri Route 1

17. (a) Burial (b) Date thereof 2-20-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Essex, Missouri.

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury \_\_\_\_\_

23. Signature John Jones M.D. (M.D. or other)

Address Morehouse Mo Date signed 2-21-48

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

(b) Address Lilbourn, Missouri.

19. (a) 2-20-48 (b) H.L. Ponder Deputy  
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

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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.....

*Homer J. Ponder*

Licensed Embalmer No.....

*9367*

P. O. Address.....

*Lilbourn, 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.**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. MarchRegistrar's No. 7Registration District No. 240Primary Registration District No. 5827

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(b) City or town Rural  
(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 NAMEGeorge H. Williams3. (b) If veteran,  
name war3. (c) Social Security  
No.

4. Sex

m5. Color or  
race w6. (a) Single, widowed, married,  
divorced

6. (b) Name of husband or wife

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

7. Birth date of deceased

(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

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)

(Burial, cremation, or removal)

(b) Date thereof

(Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a)

(Date received local registrar)

(b)

(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)

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If yes, name country

## MEDICAL CERTIFICATION

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year hour minute M.

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

Due to

Due to

Other conditions  
(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline  
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(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 (M. D. or other)

Address Date signed

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

SUPPLEMENTARY

MOTHER FATHER

S-5600 1948