

FILED MAR 6 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 5472

BIRTH NO. _____		REG. DIST. NO. <u>217</u>		PRIMARY REG. DIST. NO. <u>5787</u>		Registrar's No. <u>17</u>		
1. PLACE OF DEATH a. COUNTY <u>Mississippi</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Mississippi</u>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Charleston (Rural)</u>		c. LENGTH OF STAY (in this place) <u>27 yrs.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Charleston (Rural)</u>				
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Route 3, Box 19</u>				d. STREET ADDRESS (If rural, give location) <u>Route 3, Box 19</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>Henry</u>			b. (Middle) <u>Williams</u>			c. (Last) <u>Williams</u>		
4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 22, 1950</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		
8. DATE OF BIRTH <u>March 16, 1866</u>		9. AGE (In years last birthday) <u>83</u>		IF UNDER 1 YEAR Months <u>11</u> Days <u>6</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>			11. BIRTHPLACE (State or foreign country) <u>Lawrence County, Miss.</u>		
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13a. FATHER'S NAME <u>Jim Williams</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Mrs. Joanna Williams</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Joanna Williams</u> ADDRESS <u>R. 3 Box 19, Charleston, Mo.</u>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma Prostatic</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>177X</u>						
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <u>Feb 22 1950 10:50</u>		21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____				
22. I hereby certify that I attended the deceased from <u>Sept 8, 1949</u> , to <u>Feb 21, 1950</u> , that I last saw the deceased alive on <u>Feb 19, 1950</u> and that death occurred at <u>10:50 P.M.</u> , from the causes and on the date stated above.								
23a. SIGNATURE <u>W. E. Bernhardt</u> (Degree or title) _____				23b. ADDRESS <u>Charleston, Mo.</u>		23c. DATE SIGNED <u>27 Feb 1950</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Feb. 26, 1950</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Charleston, Mo.</u>		
DATE REC'D BY LOCAL REG. <u>Feb. 28, 1950</u>		REGISTRAR'S SIGNATURE <u>Mrs. Alex Kilgore</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>439 F. J. Sparks</u>		ADDRESS <u>Charleston, Mo.</u>		

(Licensed Embalmer's Statement on Reverse Side)

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

MAR 2 REC'D

RECEIVED

Miss. Co. Health Dept  
County File No. \_\_\_\_\_

Date Filed MAR 3 1950

**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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed Frank Sparks

Licensed Embalmer No. 3455

P. O. Address Cape Girardeau

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.

*15003 . b . f*