

Registration District No. 821

Primary Registration District No. 4553

Registrar's No. _____

1. PLACE OF DEATH: Scott
 (a) County Scott
 (b) City or town Sikeston, Mo.
 (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) 2
 (d) Length of stay: In hospital or institution _____
 (Specify whether _____)
 In this community 10 yrs
 years, months or days _____ (Specify whether _____)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo. (b) County Scott
 (c) City or town Sikeston, Mo.
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years.

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

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Jan day 25
 year 1940 hour 7:30 minute _____ P. M.

4. Sex M 5. Color or race Col 6. (a) Single, ~~widowed~~, married, divorced Married
 6. (b) Name of husband or wife Nellie Williams 6. (c) Age of husband or wife if alive 57 years
 7. Birth date of deceased Aug 12 (Month) (Day) (Year) 1877

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.

8. AGE: Years 62 Months 5 Days 12 If less than one day _____ hr. _____ min.

Immediate cause of death Acute Myocarditis
 Due to _____
 Due to _____

9. Birthplace Mo. Charleston (City, town, or county) (State or foreign country)
 10. Usual occupation Farmer

Other conditions None
 (Include pregnancy within 3 months of death)
 Major findings: _____
 Of operations _____
 Of autopsy None

11. Industry or business _____
 12. Name John Williams
 13. Birthplace Mo. (City, town, or county) (State or foreign country)
 14. Maiden name Williams
 15. Birthplace _____ (City, town, or county) (State or foreign country)

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

16. (a) Informant's own signature Nellie Williams
 (b) Address Ball Camp, Mo. Rt. 1
 17. (a) Sikeston (b) Date thereof 1-30-40
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Sikeston, Mo.
 18. (a) Signature of funeral director Andrew Ellison
 (b) Address Sikeston, Mo.
 19. (a) 4-5-1940 (b) Andrew Ellison
 (Date received local registrar) (Registrar's signature)

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? ✓
 (Specify type of place) _____
 While at work? _____ (e) Means of injury _____
 23. Signature John F. Hummel Jr. (M.D. or other) Physician
 Address Charleston, Mo. Date signed 1/31/40

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED

District Health Officer No. *24*

District File Number *440 - 90*

Date Filed *4/8/40*

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, *Jan 24*

....., Registered Apprentice No.
working under my personal supervision.

Signed *Arden Ellise*

Licensed Embalmer No. *3869*

P. O. Address *Sikeston, 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, above space should be left blank.