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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **28135**

Registration District No. **104**

Primary Registration District No. **3008**

Registrar's No. **216**

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

1. PLACE OF DEATH:
 (a) County **CALLAWAY**
 (b) City or town **FULTON**
 (c) Name of hospital or institution: **MISSOURI HOSPITAL No. 1**
 (d) Length of stay: In hospital or institution **4 yrs, 7 mo, 24 days**
 In this community **4 yrs, 7 mo, 24 days**

2. USUAL RESIDENCE OF DECEASED:
 (a) State **MISSOURI** (b) County **NEW MADRID**
 (c) City or town **Portagesville "Rural"**
 (d) Street No. **Route #3**
 (e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME **LEE WILLIAMS 452**
 (b) If veteran, name war _____ (c) Social Security No. **NONE**

4. Sex **MALE** 5. Color or race **NEGRO** 6. (a) Single, widowed, married, divorced **Single**
 (b) Name of husband or wife _____ (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **NOV. 20 1915**

8. AGE: Years **24** Months **9** Days **4** If less than one day _____ hr. _____ min.

9. Birthplace **GRADY ARKANSAS**

10. Usual occupation **LABOR**

11. Industry or business _____

MOTHER FATHER { 12. Name **KNOWLAND WILLIAMS**
 13. Birthplace **D.K.**
 14. Maiden name **D.K.**
 15. Birthplace **D.K.**

16. (a) Informant **HOSPITAL RECORDS**
 (b) Address _____

17. (a) **Burial** (b) Date thereof **Aug 31 1940**

(c) Place: burial or cremation **Hospital grounds**

18. (a) Signature of funeral director **John Thomas**

(b) Address **362 Market St. Fulton Mo**

19. (a) **Aug 31 1940** (b) **R. N. Crews**

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **August** day **24** year **1940** hour **4** minute **15** A.M.
 21. I hereby certify that I attended the deceased from **July 8**, 19**39**, to **August 24**, 19**40**;
 that I last saw him alive on **August 23**, 19**40**;
 and that death occurred on the date and hour stated above.

Immediate cause of death **Pulmonary Tuberculosis (Bilateral)**
 Duration **Chronic**
 Due to _____
 Due to _____
 Other conditions (Include pregnancy within 3 months of death) _____

PHYSICIAN
 Major findings: Of operations _____
 Of autopsy **Pulmonary tuberculosis (Bilateral)**
 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? _____
 (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 **George E. Moore** (M. D. or D. O.)
 Address **Fulton, Mo** Date signed **5-24-40**

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, 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 the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.