

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.

OCT 12 1940
Registration District No. 24

Primary Registration District No. 5779

Registrar's No. 34

1. PLACE OF DEATH:
(a) County Cape Girardeau
(b) City or town Rural, Byrd Farm
(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 2
In this community 47-4-29 years, months or days (Specify whether)

3. (a) PRINT FULL NAME AGNES Morton McWilliams
8. (b) If veteran, name war _____ 8. (c) Social Security No. none

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife C. M. McWilliams 6. (c) Age of husband or wife if alive 50 years
7. Birth date of deceased April 30 1893 (Month) (Day) (Year)

8. AGE: Years 47 Months 4 Days 29 If less than one day hr. _____ min. _____

9. Birthplace Jackson (City, town, or county) MO (State or foreign country)

10. Usual occupation Homemaker

11. Industry or business _____

MOTHER FATHER
12. Name James E. Morton
13. Birthplace near Jackson (City, town, or county) MO (State or foreign country)
14. Maiden name Magdalen E. Alexander
15. Birthplace near Jackson (City, town, or county) MO (State or foreign country)

16. (a) Informant's own signature C. J. McWilliams
(b) Address Jackson, Mo.

17. (a) Burial (b) Date thereof Oct 1-1940 (Month) (Day) (Year)
(c) Place: burial or cremation Rural Highway

18. (a) Signature of funeral director Charles Miller Jackson
(b) Address Jackson, Mo.

19. (a) 10-1-40 (b) Ed J. Schubert (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County Cape
(c) City or town Jackson Mo. R no 2 (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.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept day 29 year 1940 hour 5 minute A M.
21. I hereby certify that I attended the deceased from Sept 18, 1940, to Sept 29, 1940; that I last saw her alive on Sept 28, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Adeno-Carcinoma of uterus Duration _____
Due to _____
Due to _____

Other conditions none if _____ (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? 120
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature [Signature] (M. D. or other) _____
Address Jackson MO Date signed 10-1-40

OCT 22 1951

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 *Lynnau Steele*

Licensed Embalmer No. *2476*

P. O. Address *Jackman Ms*

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.