

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 25917

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County Pulaski
(b) City or town Ft. Leonard Wood, Mo.
(c) Name of hospital or institution:
Big Piney River
(If not in hospital or institution, write street number or location)
(d) Length of stay: 2 Months In hospital or institution. (Specify whether
In this community years, months or days)

3. (a) PRINT Calvin Williams, Jr.
FULL NAME

3. (b) If veteran, == 3. (c) Social Security
name war No.

4. Sex Male 5. Color or race Colored 6. (a) Single, widowed, married,
divorced Single
6. (b) Name of husband or wife - 6. (c) Age of husband or wife if
alive 6 years
7. Birth date of deceased February 1918
(Month) (Day) (Year)

8. AGE: Years 23 Months 5 Days 14 If less than one day
hr. min.

9. Birthplace Longbridge Louisiana
(City, town, or county) (State or foreign country)

10. Usual occupation Soldier - U.S. Army

11. Industry or business Co. B, 35 BN, Engr.

12. Name Calvin Williams

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

14. Maiden name Unknown

15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Army Records

(b) Address Ft. Leonard Wood, Missouri

17. (a) Removal (b) Date thereof July 21, 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Houston, Texas

18. (a) Signature of funeral director You Clerk

(b) Address Rolla Funeral Home - Rolla, Mo.

19. (a) 7-21-41 (b) 641 (Register's signature)
(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Texas (b) County Unknown
(c) City or town Houston
(If outside city or town limits, write "RURAL")
(d) Street No. 1313 Sydney (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country * - -

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 20
year 1941 hour 9: minute 20 A. M.

21. I hereby certify that I attended the deceased from - -
that I last saw him alive on - - 19- -
and that death occurred on the date and hour stated above.
Immediate cause of death asphyxia

Due to Drowning ?

Due to - -

Other conditions - -
(Include pregnancy within 3 months of death)

Major findings:
Of operations - -

Of autopsy Edema of lungs.
multiple petechiae of serous surfaces

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence July 20, 1941

(c) Where did injury occur? Ft. Leonard Wood, Pulaski, Mo.
(City or town) (County) (State)

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

While at work? No. (Specify type of place) (e) Means of injury Drowning

23. Signature E. C. Rogers (M. D. or other) MD

Address Ft. Leonard Wood, Mo. Date signed 7/21/41

RECEIVED

Pulaski County Health Officer

File Number 841-29

Date Filed 8-15-41

5-22464

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.....

2000
2000
working under my personal supervision.

Registered Apprentice No.

Signed

W. H. Clark

Licensed Embalmer No. 4216

P. O. Address Kalla

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 25917

Registration District No. 713

Primary Registration District No. 5942

Registrar's No.

1. PLACE OF DEATH:

(a) County Pulaski
(b) City or town St. Leonard Road
(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 NAME Calvin Williams Jr
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race C 6. (a) Single, widowed, married, divorced S
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ 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) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 71 21/14 (b) MDP. ally
(Date received local registrar) (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)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH Month July Year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;
that I saw him/her alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____ Duration _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy _____

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)

(b) 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

MOTHER FATHER

SUPPLEMENTARY

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-22464