

FILLED NOV 11 1941

Registration District No. _____

Primary Registration District No. 2009

Registrar's No. 57

1. PLACE OF DEATH:

(a) County CAPE MOO

(b) City or town CAPE GIRARDEAU, MO.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
ST. FRANCIS HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 days
(Specify whether _____)

In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County Stoddard Cape

(c) City or town Bloomfield Cape Girardeau
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location) 16

(e) Citizen of foreign country? _____ (Yes or No) 1/4
If yes, name country _____ 1/2

3. (a) PRINT FULL NAME JAMES MURLIN WILLIAMS

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced 0

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased OCT. 15 1941
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
6 hr. min.

9. Birthplace CAPE GIRARDEAU, MO. 0
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name MURLIN COLEMAN WILLIAMS

13. Birthplace MARYAN BLOOMFIELD, MO. 0
(City, town, or county) (State or foreign country)

14. Maiden name MARYAN FOSTER

15. Birthplace BLOOMFIELD MO. 0
(City, town, or county) (State or foreign country)

16. (a) Informant MURLIN C. WILLIAMS

(b) Address 278 GENEVIEVE, MO.

17. (a) Burial (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation BLOOMFIELD CEMETARY

18. (a) Signature of funeral director Chiles and Co Bloomfield, Mo.

(b) Address _____

19. (a) 10-25-41 (b) F. W. Phelps
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 21
year 1941 hour 2 minute 30 M.

21. I hereby certify that I attended the deceased from OCT 15
_____, 19____, to OCT 21, 1941

that I last saw him alive on OCT 20, 1941,
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____
Premature birth = 6 1/2 months

Due to _____

Due to _____

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

Major findings: 159
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? ✓

While at work? _____ (Specify type of place) (e) Means of injury 0

23. Signature [Signature] (M. D. or other) M.D.
Address Cape Girardeau Date signed 10-21-41

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

6
1
4

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 with 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. 34549

Registration District No. 125

Primary Registration District No. 3009

Registrar's No.

1. PLACE OF DEATH:

(a) County Cape Girardeau
(b) City or town Cape Gir.
(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)

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 _____

3. (a) PRINT FULL NAME James M Williams

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

4. Sex m 5. Color or race w 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 Oct 15 1941
(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 _____

MOTHER FATHER

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 10/22-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 10-12-9-41 (b) F.W. Phelps
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

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

21. I hereby certify that I attended the deceased from _____ 19____; that I last 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 _____

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?

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

SUPPLEMENTARY

SUPPLEMENTARY