

FILED JAN 30 1942

Registration District No. 774

Primary Registration District No. 4465

1. PLACE OF DEATH:

(a) County St. Francois  
 (b) City or town Flat River Mo  
 (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 Robt Edgar Williams

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

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

6. (b) Name of husband or wife Williams 6. (c) Age of husband or wife if alive 79 years

7. Birth date of deceased: Oct 29 (Month) 18 (Day) 66 (Year)

8. AGE: Years 74 Months 11 Days 29 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Greenville S. Carolina (City, town, or county) (State or foreign country)

10. Usual occupation Lab

11. Industry or business ad. job

12. Name Wm Williams

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

14. Maiden name Ruth Bell

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

16. (a) Informant Mary E. Williams

(b) Address Flat River Mo

17. (a) \_\_\_\_\_ (b) Date thereof 10-30-41 (Month) (Day) (Year)

(c) Place: burial or cremation Good Water Mo

18. (a) Signature of funeral director Salvatore Bros

(b) Address Flat River Mo

19. (a) 12-20-41 (b) O. Barrar (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 94  
 (c) City or town Flat River (If outside city or town limits write "RURAL") 5-2  
 (d) Street No. \_\_\_\_\_ (If rural, give location) 0  
 (e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 28 day Oct year 1941 hour 2 minute 15 AM.

21. I hereby certify that I attended the deceased from Oct 14 1941, to Oct 28 1941.

that I last saw him alive on Oct 27 1941 and that death occurred on the date and hour stated above.

Immediate cause of death Ca. of Prostate

Due to \_\_\_\_\_

Due to 516

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)

(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 7

23. Signature Chapman (M. D. or other)

Address Flat River Mo Date signed 11

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

94  
 5  
 2

RECEIVED

District Health Officer No. 4  
District File Number 142-16  
Date Filed 1-9-42

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**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, above space should be left blank.**