

FILED SEP 10 1942
Registration District No. 2288

Primary Registration District No. 4355

1. PLACE OF DEATH:

(a) County New Madrid
(b) City or town New Madrid
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: No 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution No (Specify whether)
In this community All of life years, months or days

3. (a) PRINT
FULL NAME

WILLIAMS B. ABBOTT

3. (b) If veteran,

name war No

3. (c) Social Security

No. No

4. Sex

MALE

5. Color or

race W

6. (a) Single, widowed, married,

Divorced SINGLE

6. (b) Name of husband or wife

No

6. (c) Age of husband or wife if

alive No years

7. Birth date of deceased

MAY
(Month)

13-1942
(Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

3

15

hr. min.

9. Birthplace

NEW MADRID
(City, town, or county)

MO
(State or foreign country)

10. Usual occupation

CHILD

11. Industry or business

V

12. Name

BILL ABBOTT

13. Birthplace

NEW MADRID
(City, town, or county)

MO
(State or foreign country)

14. Maiden name

ALLIE DAVIS

15. Birthplace

ORNING
(City, town, or county)

ARK.
(State or foreign country)

16. (a) Informant

BILL ABBOTT

(b) Address

NEW MADRID

17. (a)

BURIAL
(Burial, cremation, or removal)

(b) Date thereof

Aug 29-42
(Month) (Day) (Year)

(c) Place: burial or cremation

Evergreen

18. (a) Signature of funeral director

Richard Umbro

(b) Address

New Madrid, Mo.

19. (a)

Sept 1, 1942
(Date received local registrar)

(b)

Alma Spitzer
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County New Madrid
(c) City or town New Madrid
(If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 28
year 1942 hour 2:22 minute PM

21. I hereby certify that I attended the deceased from 8-6-42
....., 19..... to 8-28, 19.....
that I last saw him alive on 8-28
and that death occurred on the date and hour stated above.

Immediate cause of death

Bacillary Dysentery

Duration

3 wks

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

Alma Spitzer

(M. D.) or other

Address

New Madrid

Date signed 8-29-42

RECEIVED

District Health Office No. 2,

District File Number 942-1146

Date Filed 9-8-42

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.