S. No. 2
M—5-42
V. 17-39
X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 2 1943

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 6503

Registration District No. 7403 Primary Registration District No. 3024 Registrar's No. 12

1. PLACE OF DEATH:
(a) County: Howard
(b) City or town: Fayette (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 204 W. Hackleberry St (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ In this community: about 45 yrs (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Howard
(c) City or town: Fayette (If outside city or town limits, write "RURAL")
(d) Street No.: 204 W. Hackleberry (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country: 0

3. (a) PRINT FULL NAME: JAMES WILLIAMS
3. (b) If veteran, name war: ____
3. (c) Social Security No.: ____
4. Sex: Male
5. Color or race: Negro
6. (a) Single, widowed, married, divorced: widow
6. (b) Name of husband or wife: Letha Williams
6. (c) Age of husband or wife if alive: ____ years
7. Birth date of deceased: 2-28-1898 (Month) (Day) (Year)
8. AGE: Years 44 Months 11 Days 17 If less than one day ____ hr. ____ min.
9. Birthplace: Howard Co. (City, town, or county) Mo. (State or foreign country)
10. Usual occupation: Farm hand
11. Industry or business: Farm
MOTHER FATHER
12. Name: unknown
13. Birthplace: 9 (City, town, or county) (State or foreign country)
14. Maiden name: unknown
15. Birthplace: 9 (City, town, or county) (State or foreign country)
16. (a) Informant: Dallie Williams
(b) Address: Fayette Missouri
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 2-21-1943 (Month) (Day) (Year)
(c) Place: burial ~~or cremation~~: Hillsdale Mo.
18. (a) Signature of funeral director: Steve Davis
(b) Address: Columbia, Missouri
19. (a) 2-16 1943 (Date received by local registrar) (b) Ernest McMillan (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 15th year 1943 hour 9 minute 45 P.M.
21. I hereby certify that I attended the deceased from Dec. 12, 1942, to Feb. 15th, 1943; that I last saw him alive on Feb. 15th, 1943; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Tuberculosis	8 yrs.
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death): none	

Major findings:
Of operations: none
Of autopsy: none

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

23. Signature: M. P. Leech MD (M. D. or other) MD
Address: Lee Hospital, Fayette, Mo. Date signed 2/16/43

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8
District File Number
Date Filed 3-10-43

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 Elmer D. Parker

Licensed Embalmer No. 2900

P. O. Address Columbia

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.

V. S. No. 2B
0M—8-21-41
I X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 6503

Registration District No. ..... Primary Registration District No. 3024 Registrar's No. .....

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

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Howard

(b) City or town Fayette
(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 45 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Howard

(c) City or town Fayette
(If outside city or town limits, write "RURAL")

(d) Street No. 204 W Hackberry
(If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME James Williams

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

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

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

7. Birth date of deceased Feb 28 (Month) 1898 (Day) (Year)

8. AGE: Years 44 Months 11 Days 17 If less than one day ..... or ..... min.

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

10. Usual occupation .....

11. Industry or business .....

FATHER
12. Name .....
13. Birthplace ..... (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name .....
15. Birthplace ..... (City, town, or county) (State or foreign country)

16. (a) Informant .....
(b) Address .....

17. (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (Month) (Day) (Year)
(c) Place: burial or cremation .....

18. (a) Signature of funeral director .....
(b) Address .....

19. (a) ..... (Date received local registrar) (b) ..... (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 15
year 1943 hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from ..... 19..... to ..... 19.....;
that I last saw h..... alive on ..... 19.....;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Tuberculosis Lungs	2 yrs
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations ..... 13 b'
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)
(b) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? ..... (e) Means of injury .....

23. Signature W L Leech M (M.D. or other)
Address ..... Date signed .....