

S. No. 2
M-9-4-41
5-17-39
X294

14994

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

Registrar's No.

FILED MAY 7 1943 17

Primary Registration District No. 5787

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

1. PLACE OF DEATH:

(a) County MISSISSIPPI

(b) City or town: DEVENTER (RURAL)
(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) 1 Zuyawanta, 2nd

(d) Length of stay: In hospital or institution 5 YEARS (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County MISSISSIPPI

(c) City or town DEVENTER, MO. (RURAL)
(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 A

3. (a) PRINT FULL NAME ROBERT WILLIAMS

3. (b) If veteran, name war NO

3. (c) Social Security No. NO

4. Sex M

5. Color or race COL

6. (a) Single, widowed, married, divorced SINGLE

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive 12 years (Day) (Year)

7. Birth date of deceased JULY 12 1928
(Month) (Day) (Year)

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

14 8 18 hr. min.

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

10. Usual occupation SCHOOL

11. Industry or business At Home

12. Name TOMMIE JACOB

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

14. Maiden name JESSIE FOWLER

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

16. (a) Informant W. C. S. FOWLER

(b) Address Rt 1 BOX 129 CHARLESTON, MO.

17. (a) RURAL (b) Date thereof 4 1 43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation DAVE GROVE CEM

18. (a) Signature of funeral director W. A. Fugate

(b) Address Charleston Mo

19. (a) 5/14/43 (b) Wm Tom Jacob
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MARCH day 29th
year 1943 hour 10 o'clock minute P.M.

21. I hereby certify that I attended the deceased from 3-29, 1943 to ---, 19---
that I last saw him alive on 3-29, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia

Due to 104

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

Duration 9 days

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) (a) Means of injury ---

23. Signature W. A. Fugate (M. D. or other)

Address 204 S. Court St Charleston, Mo Date signed 3-2-43

1257

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Office. No. 2

District File Number 543-613

Date Filed 5-6-48

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

John P. Munnice Jr

Licensed Embalmer No. 3851

P. O. Address Charleston Mo.

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.