

APR 22 1943
Registration District No. 3303

Primary Registration District No. 2077 6715 3 074 Registrar's No.

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

1. PLACE OF DEATH:

(a) County Scott

(b) City or town Sikeston
(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 4 years
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Tom Williams

3. (b) If veteran, name war X

3. (c) Social Security No. 498-14-3157

4. Sex M

5. Color or Race C

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 1 30 1914
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>29</u>	<u>2</u>	<u>6</u>	<u>hr. min.</u>

9. Birthplace Shelby Co. Tenn. /
(City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business

MOTHER { 12. Name Aaron Williams

13. Birthplace Jackson Tenn. /
(City, town, or county) (State or foreign country)

14. Maiden name Bertha Taylor

15. Birthplace Shelby Co. Tenn. /
(City, town, or county) (State or foreign country)

16. (a) Informant Aaron Williams

(b) Address Sikeston Mo. R. #. 1 Box 10

17. (a) Burial (b) Date thereof 4/8/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sikeston Mo.

18. (a) Signature of funeral director H. W. Albritton

(b) Address Sikeston Mo.

19. (a) 9-18-43 (b) Lavin Largent
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Scott

(c) City or town Sikeston
(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 4 day 6
year 1943 hour 11 minute 30 a. m.

21. I hereby certify that I attended the deceased from Dec 10
1942 to April 5 1943;
that I last saw him alive on April 5 1943;
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia

Due to Bronchitis Duration 4 mos

Due to

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

PHYSICIAN

Major findings:
Of operations

Of autopsy

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 J. F. Nates (M. D. or other) D

Address Sikeston Mo Date signed 4-6-43

RECEIVED

District Health Office No. 2,

District File Number 443-556

Date Filed 4-21-43

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.....

..... Embalmed, Registered Apprentice No.....
working under my personal supervision.

Signed Hunter Abbotton

Licensed Embalmer No. 4210

P. O. Address Sikeston 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 15-654
Registrar's No. _____

Registration District No. 233

Primary Registration District No. 3074

1. PLACE OF DEATH:

(a) County Scott
(b) City or town Sheridan
(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 _____ (Specify whether)
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 Tom 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 S

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

7. Birth date of deceased Jan 30 1943
(Month) (Day) (Year)

8. AGE: Years 29 Months 2 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry of business _____

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 _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia
Bronchial

Due to Bronchitis

Due to _____

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

Major findings: 107
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 _____

23. Signature J.F. Waters (M. D. or other) _____

Address Sheridan Date signed 6-1-43

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

SUPPLEMENTARY

MOTHER FATHER

PHYSICIAN
Underline the cause to which death should be charged statistically.

S-15654

P. E. Hester

Sikeston, Mo.