

Registration District No. 53

Primary Registration District No. 3010

Registrar's No. 94

1. PLACE OF DEATH:

(a) County Cape Girardeau  
(b) City or town Cape Girardeau  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
R. 2, Box 435, Smelterville  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 1/2 months  
(Specify whether years, months or days)  
In this community 3 1/2 months

3. (a) PRINT FULL NAME Carl G. 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. 2

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

7. Birth date of deceased Nov. 17, 1943  
(Month) (Day) (Year)

8. AGE: Years None Months 3 Days 15 If less than one day hr. min.

9. Birthplace Cape Girardeau, Mo. 0  
(City, town, or county) (State or foreign country)

10. Usual occupation -----

11. Industry or business -----

12. Name Leroy Wingstaff  
13. Birthplace Tennessee 9  
(City, town, or county) (State or foreign country)

14. Maiden name Ida Mae Williams 0  
(City, town, or county) (State or foreign country)

15. Birthplace Cape Girardeau, Mo. 0  
(City, town, or county) (State or foreign country)

16. (a) Informant Ida Mae Williams (mother)  
(b) Address R. 2, Box 435, Cape Girardeau, Mo.

17. (a) Burial (b) Date thereof March 3, 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Fairmont Cemetery

18. (a) Signature of funeral director F. J. Sparks  
(b) Address Cape Girardeau, Mo.

19. (a) 3-7-44 (b) F. J. Phelps  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cape Girardeau 16  
(c) City or town Cape Girardeau 0  
(If outside city or town limits, write "RURAL")  
(d) Street No. R. 2, Box 435, Smelterville  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country -----

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 3  
year 1944 hour 10: minute 10 A.M.

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

Immediate cause of death Malnutrition  
Due to Whooping Cough.

Due to -----  
Other conditions (Include pregnancy within 3 months of death) -----  
Major findings: Of operations 9  
Of autopsy -----

Duration

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 Dr. J. F. Lyman, Coroner  
Address Jackson, Mo. Date signed 3/4/44

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

1600

1014

RECEIVED

District Health Officer No. 4  
District File Number 444-365  
Date Filed 4-7-44

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

*Frank Sparks*

Licensed Embalmer No.

3455

P. O. Address

*C/o Anderson Co*

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.