

FILED JAN 15 1945

Registration District No. \_\_\_\_\_ Primary Registration District No. **9010**

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

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: **St. Francis Hosp.**  
(If not in hospital or institution, write street number or location)

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

In this community **5 day**  
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **new, malind**

(c) City or town **Rural** **72**  
(If outside city or town limits, write "RURAL")

(d) Street No. **Matthews Mo R. 90**  
(If rural, give location)

(e) Citizen of foreign country? **no** (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **JOHN E. WILLIAMS**

(b) If veteran, name war \_\_\_\_\_

(c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov** day **2** #  
year **1944** hour **4:35** minute **P.** M.

4. Sex **male**

5. Color or race **white**

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

(b) Name of husband or wife \_\_\_\_\_

(c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: **July 14** **1872**  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Nov 21** 19**44** to **Nov 24** 19**44**  
that I last saw him alive on **Nov 24** 19**44**  
and that death occurred on the date and hour stated above.

8. AGE: Years **72** Months **4** Days **10**  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Immediate cause of death: **Carcinoma of stomach with general metastasis**  
Due to \_\_\_\_\_  
Due to **Hb**

Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

9. Birthplace \_\_\_\_\_ (City, town, or county) **Tenn** (State or foreign country)

10. Usual occupation **Farmer**

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name **Thomas Williams**

13. Birthplace **OK** (City, town, or county) (State or foreign country)

14. Maiden name **OK**

15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

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? \_\_\_\_\_

16. (a) Informant **L E Silvesthorn**

(b) Address **Matthews Mo R**

While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury **0**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **11-27-44** (Month) (Day) (Year)

(c) Place: burial or cremation **Stanton Mo**

18. (a) Signature of funeral director: **Welch Funeral Home**

(b) Address **Stanton Mo**

19. (a) **12-21-44** (Date received local registrar) (b) **H. M. Phelps** (Registrar's signature)

23. Signature **P. C. Ritter, M.D.** (M. D. or other) \_\_\_\_\_  
Address **Cape Girardeau Mo** Date signed **12-20-44**

Duration \_\_\_\_\_

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

RECEIVED

District Health Officer No. 4

District File Number 145-51

Date Filed 1-8-45

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 Raymond Crews

Licensed Embalmer No. 3467

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.