

FILED APR 1 1945

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

5820-4353

Registrar's No. 5

1. PLACE OF DEATH

(a) County New Madrid  
(b) City or town Sidon  
(c) Name of hospital or institution: Anderson Hosp  
(If not in hospital or institution, write street number or location) \_\_\_\_\_  
(d) Length of stay: In hospital or institution 15 yr (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County New Madrid  
(c) City or town Sidon Mo (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 William W. Wadsworth

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 16  
year 1945 hour 5 minute 18 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 Cardio renal disease Duration 2 yr

Due to cardio renal

Due to \_\_\_\_\_

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

Major findings: Of operations \_\_\_\_\_ 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) \_\_\_\_\_ (d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

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

23. Signature John E. ... (M. D. or other) MA  
Address Adams Date signed 1/16/45

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Lida M. Wadsworth 6. (c) Age of husband or wife if alive 52 years

7. Birth date of deceased: May 25 1880  
(Month) (Day) (Year)

8. AGE: Years 64 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Flaming

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

12. Name James Wadsworth

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

14. Maiden name Parthana Blatter

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

16. (a) Informant Lida Wadsworth

(b) Address Sidon Mo

17. (a) Burial (b) Date thereof 1-17-1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Malden

18. (a) Signature of general director W. H. Spay

(b) Address Director, Ark

19. (a) Jan 16 - 1945 (b) James Wadsworth  
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

RECEIVED

District Health Office No. 2,

District File Number 442-262

Date Filed APR 11 1945

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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 R. Casner

Licensed Embalmer No. 2912

P. O. Address Rector, Ark

**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.**