

No. 2
-2-43
17-39
X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

21055

FILED JUN 24 1946

Registration District No. 267

Primary Registration District No. 5902

State File No. _____

Registrar's No. 32

1. PLACE OF DEATH: *Remick Hayti*

(a) County: *Remick*

(b) City or town: *Rural Hayti*
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: *1*
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
In this community *1 yr - 2 mo 26 da* (Specify whether years, months or days)

3. (a) PRINT FULL NAME: *Andrew L. Williams*

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex: *Male* 5. Color: *col* 6. (a) Single, widowed, married, divorced: *single*

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

7. Birth date of deceased: *3 20 1945*

8. AGE: Years *1* Months *2* Days *26* If less than one day hr. _____ min. _____

9. Birthplace: *Hayti* (City, town, or county) *MO* (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name: *A. Williams*

13. Birthplace: *Hinds County Miss* (City, town, or county) (State or foreign country)

14. Maiden name: *Carrie Walker*

15. Birthplace: *Hinds County Miss* (City, town, or county) (State or foreign country)

16. (a) Informant: *A. Williams*

(b) Address: *Hayti - MO*

17. (a) *Burial* (b) Date thereof: *4-17-46* (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: *Hayti - Miss*

18. (a) Signature of funeral director: *H. J. Smith*

(b) Address: *Hayti - MO*

19. (a) *6-20-46* (b) *Dee Dee Keller* (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State: *Missouri* (b) County: *Remick*

(c) City or town: *Hayti*
(If outside city or town limits, write "RURAL")

(d) Street No.: *Rural* (If rural, give location)

(e) Citizen of foreign country? *NO* (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *June* day *16* year *1946* hour *1* minute *A.* M.

21. I hereby certify that I attended the deceased from *June 12 1946* to *June 16 1946* that I last saw him alive on *June 15 1946* and that death occurred on the date and hour stated above.

Immediate cause of death: *hemiparesis*

Due to: *Rockets*

Due to: _____

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

Major findings: *86*

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)

(e) Means of injury _____

23. Signature: *W. Bond M.D.* (M. D. or other) _____

Address: *Hayti, MO* Date signed: _____

565 (Licensed Embalmer's Statement on Reverse Side)

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

81 8T 707

Not Embalmed

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.....

Licensed Embalmer No.....

P. O. Address.....

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.

Registration District No. 267 Primary Registration District No. 5902

1. PLACE OF DEATH:

(a) County Pemiscot
(b) City or town Rural
(If outside city or town limits, write "RURAL" add 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 _____
years, months or days

3. (a) PRINT FULL NAME Andrew L. 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 _____

7. Birth date of deceased mar 20
(Month) (Day) (Year)

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

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Pemiscot
(c) City or town Hoyt, 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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____
year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 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 _____

Due to _____

Due to _____

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

Major findings: 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 _____ (M. D. or other) _____

Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

21055