

No. 2  
-1/47  
5-17-39

National Office of Vital Statistics  
FILED DEC 15 1947

Registration District No. **238**

Primary Registration District No. **5823**

1. PLACE OF DEATH:

(a) County **New Madrid**  
(b) City or town **Rural**  
(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 **15 years**  
(Specify whether years, months or days)

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

3. (b) If veteran,  name war **✓**  
3. (c) Social Security No. **✓**

4. Sex **M**  
5. Color or race **col**  
6. (a) Single, widowed, married, divorced **2**  
6. (b) Name of husband or wife  
6. (c) Age of husband or wife if alive **years 187**  
7. Birth date of deceased **Feb 1871**  
(Month) (Day) (Year)

8. AGE: Years **72** Months **9** Days **28**  
If less than one day hr. min.

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

10. Usual occupation **FARM LABOR**

11. Industry or business **✓**

12. Name **Robert Williams**

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

14. Maiden name  
15. Birthplace **UNK**  
(City, town or county) (State or foreign country)

16. (a) Informant **ELMORE BROWN**

(b) Address **40 Festus, MO**

17. (a) **BURIAL** (b) Date thereof **Dec 7-47**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **CRYSTAL CITY, MO**

18. (a) Signature of funeral director **Rutledge Ind Co**

(b) Address **New Madrid, Mo**

19. (a) **12-2-47** (b) **Helen Rutledge**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **New Madrid**  
(c) City or town **Rural**  
(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 **Nov** day **30**  
year **1947** hour **10:00** minute **AM**

21. I hereby certify that I attended the deceased from **Nov 27** 19**47** to **Nov 30** 19**47**  
that I last saw him alive on **Nov 27** 19**47**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Senility -**

Due to **Old age & the infirmities thereof -**

Due to

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations **11/17**

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature **O.B. Chandler** (M. D. or other) **MD**

Address **New Madrid Mo** Date signed **12/1/47**

Duration  
PHYSICIAN  
Underline the cause of which death should be charged statistically.

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

MOTHER FATHER

RECEIVED

District Health Office No. 2,

District File Number 12-47-1582

Date Filed 12-11-47

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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 \_\_\_\_\_

Allen C. McSpencer, Registered Apprentice No. 512  
working under my personal supervision.

Signed L. August

Licensed Embalmer No. 3803

P. O. Address New Market, 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.