WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Adair

Township or Village or City Kirksville (NO. 1501 N Elliston St.; Ward)

Registration District No. 4 File No. 5

Primary Registration District No. 3001 Registered No. 149

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Emma May Williams

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): child

DATE OF BIRTH: Jan 8th (Month) (Day), 1914 (Year)

AGE: ..... yrs. ..... mos. 1 ds. If LESS than 1 day 2 hrs. or ..... min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: child
(b) General nature of industry, business, or establishment in which employed (or employer): — — —

BIRTHPLACE (City or town, State or foreign country): Kirksville Mo

PARENTS

NAME OF FATHER: A. T. Williams

BIRTHPLACE OF FATHER (City or town, State or foreign country): Ill

MAIDEN NAME OF MOTHER: Lilly Anthony

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Adair Co Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A T Williams

(ADDRESS) Kirksville Mo

Filed Jan 9 1914 A W Parrish REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Jan 9 (Month) (Day), 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from Jan. 8, 1914, to Jan. 8, 1914, that I last saw her alive on Jan 8, 1914, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Mitral insufficiency congenital

157C

(Duration) ..... yrs. ..... mos. 1 da

Contributory (SECONDARY): Imperfect formation of heart (Duration) ..... yrs. ..... mos. 1 da

(Signed) W W Martin M. D.

Jan 9, 1914 (Address) Kirksville Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury: and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL: Llewellyn

DATE OF BURIAL: Jan. 9, 1914

UNDERTAKER: H. C. Wilson

ADDRESS: Kirksville Mo.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County.....

Township ..... Registration District No..... File No.....

or

Village..... Primary Registration District No..... Registered No.....

or

City .....(NO. ....., ...St.; .....Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME.....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

....., 1.....
(Month) (Day) (Year)

AGE

.....yrs.....mos.....ds.

If LESS than 1 day,.....hrs. or.....min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).....

(ADDRESS).....

Filed ....., 191...., ...
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

....., 191....
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from ....., 191...., to....., 191...., that I last saw h.....alive on....., 191...., and that death occurred, on the date stated above, at.....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs.....mos.....ds.

Contributory.....
(SECONDARY)

.....(Duration).....yrs.....mos.....ds.

(Signed)..... M. D.

....., 191.... (Address).....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted if not at place of death? .....

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	....., 191....
UNDERTAKER	ADDRESS