

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

PLACE OF DEATH

County Texas
Township Oass
or
Village
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 865 File No. 11362
Primary Registration District No. 6143 Registered No. _____

FULL NAME

Carson Williams

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

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Male COLOR OR RACE White SINGLE MARRIED Married
WIDOWED
OR DIVORCED
(If write the word)

DATE OF DEATH March 11, 1914
(Month) (Day) (Year)

DATE OF BIRTH Dec 25, 1826
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from March 7, 1914, to March 11, 1914, that I last saw him alive on March 10, 1914, and that death occurred, on the date stated above, at 8 A. m.

AGE 88 yrs. 2 mos. 14 ds. If LESS than 1 day, ___ hrs. or ___ min.?

The CAUSE OF DEATH* was as follows:

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

Pneumonia

BIRTHPLACE (City or town, State or foreign country) Jackson Co Mo.

(Duration) ___ yrs. ___ mos. 4 ds.

PARENTS
NAME OF FATHER Noah Williams
BIRTHPLACE OF FATHER I think Ohio
(City or town, State or foreign country)
MAIDEN NAME OF MOTHER Don't know
BIRTHPLACE OF MOTHER I think Ohio
(City or town, State or foreign country)

Contributory (SECONDARY) _____ (Duration) ___ yrs. ___ mos. ___ ds.
(Signed) J. Cavalier M. D.
4-12, 1914 (Address) Depone 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.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Williams
(ADDRESS) St. Louis Mo

Where was disease contracted if not at place of death?
Former or usual residence _____

Filed 3-12, 1914 G. W. Keasom
REGISTRAR

PLACE OF BURIAL OR REMOVAL Morgan Cemetery DATE OF BURIAL 4-12, 1914
UNDERTAKER W. C. Kidd ADDRESS Tyngton Mo

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.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 8 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc. of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*

Whooping cough; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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.

PLACE OF BIRTH

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATED UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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

County Texas Registration District No. 865 File No. _____
 or _____
 Township Cass Primary Registration District No. 6143 Registered No. 6
 or _____
 Village _____
 or _____
 City _____ (NO. _____ St. _____ Ward _____)

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

FULL NAME Arnon Williams

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>M</u>	COLOR OR RACE <u>W</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>M</u>
DATE OF BIRTH <u>Dec</u> <u>26</u> , 19 <u>26</u> (Month) (Day) (Year)		
AGE <u>87</u> yrs. <u>2</u> mos. <u>16</u> ds. If LESS than 1 day, hrs. or min.		
OCCUPATION (a) Trade, profession, or particular kind of work <u>Farm</u> (b) General nature of industry, business, or establishment in which employed (or employer)		
BIRTHPLACE (City or town, State or foreign country) <u>Laurens, Mo.</u>		
PARENTS	NAME OF FATHER <u>Noah Williams</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Stark, Ohio</u>	
	MAIDEN NAME OF MOTHER <u>Edith Knowlton</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Stark, Ohio</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb 11, 1944
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Mar 11, 1944 at Laurens, Mo.
 Satisfactory Information Supplied: 1944
 that I last saw him alive on Mar. 10, 1944
 and that death occurred, on the date stated above, at 8:00 m.
 The CAUSE OF DEATH* was as follows:
Pneumonia Lobar
 (Duration) yrs. mos. ds.

Contributory (SECONDARY)
 (Duration) yrs. mos. ds.
 Signed J. P. Barlier M. D.
4111 1944 (Address) Lynon, 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
Morgan Cemetery

DATE OF BURIAL
4-12, 1944

UNDERTAKER
Ed. Field

ADDRESS
Lynon, Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) John Williams
 (ADDRESS) Stark, Mo.
 Filed 3/12 1944 by J. P. Barlier
 REGISTRAR

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

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