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 Cole

Township _____ Registration District No. 213- File No. 21363

or

Village _____ Primary Registration District No. 3014- Registered No. 112-

or

City Jefferson (NO. Monroe St.; _____ Ward)

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

FULL NAME James N. Williams

PERSONAL AND STATISTICAL PARTICULARS

SEX: M

COLOR OR RACE: Negro

~~SINGLE~~ MARRIED ~~WIDOWED~~ ~~OR DIVORCED~~ ~~(Write the word)~~ Married

DATE OF BIRTH: Unk (Month) _____ (Day), 1874 (Year)

AGE: 41 yrs. _____ mos. _____ ds. If LESS than 1 day, ____ hrs. or ____ min.?

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

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

PARENTS
NAME OF FATHER: Earl Williams
BIRTHPLACE OF FATHER (City or town, State or foreign country): Texas
MAIDEN NAME OF MOTHER: Eliza Leonard
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Jefferson City

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm J Thompkins

(ADDRESS) 1509-E-18 St Kans City Mo

Filed July, 12-, 1915. S. V. Bedford REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: July (Month) 11 (Day), 1915 (Year)

I HEREBY CERTIFY, that I attended deceased from May 30th, 1915, to July 11th, 1915, that I last saw him alive on July 10, 1915, and that death occurred, on the date stated above, at 1:30 A. m.

The CAUSE OF DEATH* was as follows:

Acute Parenchymatous Nephritis

130 (Duration) 130 yrs. 1½ mos. _____ ds.

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) H. E. Johnson M. D.

7-12-, 1915 (Address) 505 Monroe

*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: Jeff City Mo

DATE OF BURIAL: 7/12/15 1915

UNDERTAKER: Chas Heinrich

ADDRESS: Jeff City 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