

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 DEATH

County Pettis

Township _____

or

Village _____

or

City Lebanon

(NO

Registration District No. _____

Primary Registration District No. 302

File No. _____

Registered No. 308

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

FULL NAME Ralph Williams

PERSONAL AND STATISTICAL PARTICULARS

SEX M COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED (If file the word)

DATE OF BIRTH July 26 1917 (Month) (Day) (Year)

AGE 60 yrs. 4 mos. 4 ds. If LESS than 1 day, ____ hrs. or ____ min.?

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

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

PARENTS NAME OF FATHER G. F. Williams BIRTHPLACE OF FATHER (City or town, State or foreign country) Mo MAIDEN NAME OF MOTHER Jaily Dwyer BIRTHPLACE OF MOTHER (City or town, State or foreign country) Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R. F. Williams (ADDRESS) Lebanon Mo

Filed Nov 26 1917 F. B. Long REGISTRAR

MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

39053

668

3032

302 E Shiloh

St.

Ward

DATE OF DEATH

Nov 23

(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from

Oct 1, 1917, to Nov 23, 1917,

that I last saw him alive on Nov 24, 1917,

and that death occurred, on the date stated above, at 5 m.

The CAUSE OF DEATH* was as follows:

34 Enteric Meningitis

Lucie

(Duration) 61 yrs. 1 mos. 1 ds.

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

(Signed) At Monro M. D.

Nov 26, 1917 (Address) At Monro

*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 Crown Hill

DATE OF BURIAL Nov 26 1917

ADDRESS Lebanon Mo

PREPARATOR Plaly W. W. Co

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

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

PLACE OF DEATH

County _____

Township _____
or _____

Village _____
or _____

City _____ (NO. _____)

Registration District No. _____

File No. _____

Primary Registration District No. _____

Registered 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 (If file the word)
DATE OF BIRTH _____ (Month) _____, 191____ (Day) _____, 191____ (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) _____		

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____, 191____ (Day) _____, 191____ (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)

(Signed) _____ (Duration) _____ yrs. _____ mos. _____ ds.

_____ (Signed) _____ (Duration) _____ yrs. _____ mos. _____ ds.

_____ 191____ (Address) _____ M. D.

*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

UNDERTAKER

ADDRESS

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191____

REGISTRAR

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)