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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCR D BY LAW.

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

PLACE OF DEATH

County Lawrence

Township —

or

Village —

or

City Peirce City (NO. ..... St.: ..... Ward)

Registration District No. 471 File No. 2

Primary Registration District No. 4284 Registered No. 11 1912

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

FULL NAME Robert A. Williams

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

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

DATE OF BIRTH: Sept (Month) 25 (Day), 1915 (Year)

AGE: 2 yrs. 3 mos. 9 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) McGill Nevada

PARENTS
NAME OF FATHER: Loran Williams
BIRTHPLACE OF FATHER (City or town, State or foreign country) Ind
MAIDEN NAME OF MOTHER: Addey Jemmerson
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Peirce City

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Loren Williams

(ADDRESS) McGill Nevada

Filed Jan 4, 1918. J. E. Barnhill REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Jan (Month) 3 (Day), 1918 (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 1, 1917, to Jan 3, 1918, that I last saw ~~him~~ alive on Jan 3, 1918, and that death occurred, on the date stated above, at 3:10 PM.

The CAUSE OF DEATH* was as follows:

Septic meningitis

79A 01

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

Contributory (SECONDARY) Typhoid fever

(Duration) ..... yrs. 1 mos. — ds.

(Signed) J. E. Barnhill M. D.

Jan 4, 1918 (Address) Peirce City 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: Peirce City Mo

DATE OF BURIAL: Jan 4, 1918

UNDERTAKER: John Seefert

ADDRESS: Peirce City Mo

PLACE OF DEATH

County.....

Township .....
or
Village.....
or
City .....(NO. ..... St.; ..... Ward)

MISSOURI STATE BOARD OF H
BUREAU OF VITAL STATISTIC
CERTIFICATE OF DEATH

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

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

[If death hospital give its of street a

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH

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

..... (Month) ..... (Day)

I HEREBY CERTIFY, that I attended dece

....., 191...., to .....

that I last saw h..... alive on .....

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) ..... yrs. ..... mo

Contributory .....
(SECONDARY)

..... (Duration) ..... yrs. ..... mo

(Signed) .....

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

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRAN RECENT RESIDENTS)

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

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

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL	DATE OF BURI
UNDERTAKER	ADDRESS

Revised United States Standard
Certificate of Death

"Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lung*