

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

14045

1 PLACE OF DEATH  
County *Montgomery*

Township \_\_\_\_\_

Village *Halls*

City \_\_\_\_\_

Registration District No. *595*

File No. *126*

Primary Registration District No. *4353*

Registered No. *126*

2 FULL NAME *Abraham Lincoln Williams*

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

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male*  
4 COLOR OR RACE *(Col)*  
5 SINGLE *Divorced*  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH  
(Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_

7 AGE *62*  
If LESS than 1 day \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?  
\_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

8 OCCUPATION  
(a) Trade, profession, or particular kind of work *Poultry feeder*  
(b) General nature of industry business, or establishment in which employed (or employer) *same*

9 BIRTHPLACE  
(City or town, State or foreign country) *Halls Mo*

10 NAME OF FATHER *Jarrett Williams*

11 BIRTHPLACE OF FATHER *West Liberty Mo*

12 MAIDEN NAME OF MOTHER *Maisy Williams*

13 BIRTHPLACE OF MOTHER *Prussia Mo*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
*H. B. Prewitt*  
(Informant) *Jarrett Williams*  
(Address) *Wilberville Mo*

15 Filed *April 15 1918*  
*Geo. Prewitt*  
Registrar

MEDICAL CERTIFICATE OF DEATH

10 DATE OF DEATH *Apr 4 1918*  
(Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_

17 I HEREBY CERTIFY, that I attended deceased from *my* \_\_\_\_\_ 191*8* to *Apr* \_\_\_\_\_ 191*8*  
that I last saw *him* alive on *Apr 4* \_\_\_\_\_ 191*8*  
and that death occurred, on the date stated above, at *8 P* m.

The CAUSE OF DEATH\* was as follows:  
*Acute Cardiac*  
*Asthma*  
*7/12* *19*

CONTRIBUTORY *Acute*  
(Secondary) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs \_\_\_\_\_ mos \_\_\_\_\_ ds.

(Signed) *Geo. B. Prewitt* M. D.  
*4/6* 191*8* (Address) *Wilberville*

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

18 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 \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL *Wilberville* DATE OF BURIAL *7/6* 191*8*

20 UNDERTAKER *C. B. Halls* ADDRESS *Halls Mo*

# 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*, *Compositor*, *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, 6 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.)

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PLACE OF DEATH  
County St. Louis  
Township Wellsville Registration District No. 575 File No. 126  
Village Wellsville Primary Registration District No. 4353 Registered No. 126  
City Wellsville (NO.      St.      Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)  
2 FULL NAME Abraham Lincoln Williams

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX M 4 COLOR OR RACE B 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) SW

16 DATE OF DEATH Apr 4 8  
(Month) (Day) (Year)

6 DATE OF BIRTH unknown  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from 191 to 191, that I last saw him alive on 191, and that death occurred, on the date stated above, at      m. The CAUSE OF DEATH\* was as follows:

7 AGE unknown If LESS than 1 day hrs. or min.?

Satisfactory Information Supplied.

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

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

CONTRIBUTORY (Secondary)      (Duration)      yrs.      mos.      ds. (Signed)      M. D.      191 (Address)     

PARENTS 10 NAME OF FATHER      11 BIRTHPLACE OF FATHER (City or town, State or foreign country)      12 MAIDEN NAME OF MOTHER      13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)     

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14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant)      (Address)     

19 PLACE OF BURIAL OR REMOVAL      DATE OF BURIAL      191 20 UNDERTAKER      ADDRESS     

15 Filed April 15 8 191 8 Yes. E. Pruitt Registrar

Satisfactory Information Supplied.

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