LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

27687

V. S. No. 2.

MARGIN RESERVED FOR BINDING

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.

PLACE OF DEATH

County: [illegible] Registration District No.: 744 File No.:

Township: Richmond Primary Registration District No.: [illegible] Registered No.: 936

City: [illegible] (No.: St.: Ward:)

FULL NAME: Joseph J. Williams

(a) Residence. No.: St.: Ward: (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Eliza Williams

DATE OF BIRTH (MONTH, DAY AND YEAR): 1/23/1843

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	6	19	

OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer:

BIRTHPLACE (CITY OR TOWN):

(STATE OR COUNTRY): Kentucky

10. NAME OF FATHER: J. Williams

11. BIRTHPLACE OF FATHER (CITY OR TOWN): Ky

(STATE OR COUNTRY): Elizabethtown

12. MAIDEN NAME OF MOTHER: Ky.

13. BIRTHPLACE OF MOTHER (CITY OR TOWN):

(STATE OR COUNTRY): Ky.

INFORMANT: J. Williams

(Address): Richmond Mo

FILED: Aug 6, 1920 R. L. Hamilton, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Aug 6 1920

17. I HEREBY CERTIFY, That I attended deceased from May 1, 1920 to Aug 4, 1920, that I last saw h. alive on Aug 4, 1920 and that death occurred, on the date stated above, at 4:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Apoplexy

Fr. 2. 64

162 (duration) 3 yrs. 4 mos. ds.

CONTRIBUTORY (SECONDARY): Age

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED: —

IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? No DATE OF

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Symptoms

(Signed) R. L. Hamilton, M. D.

Aug 6, 1920 (Address) Richmond Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREATION, OR REMOVAL: Antioch

DATE OF BURIAL: 8/6 1920

20. UNDERTAKER: [illegible]

ADDRESS: Richmond Mo

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

1. PLACE OF DEATH

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

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

City..... (No....., ...St. .....Ward

2. FULL NAME .....

(a) Residence. No..... St., ...Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. d

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE — YEARS | MONTHS | DAYS | If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY)

14.
INFORMANT .....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

17.
I HEREBY CERTIFY, That I attended deceased from .....
.....,19....., to ....., 19..
that I last saw h..... alive on....., 19....., and
death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

.....(duration).....yrs. .....mos.

CONTRIBUTORY.....
(SECONDARY)

.....(duration).....yrs. .....mos.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed).....,

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, sta (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL | DATE OF BURIAL 19

20. UNDERTAKER | ADDRESS