

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

4850

**1. PLACE OF DEATH**

County Jackson Registration District No. 300 File No. 4850  
 Township Kaw Primary Registration District No. 800 Registered No. 100  
 City Kansas City (No. 416 West 35th St. St. 100 Ward)

**2. FULL NAME**

ARTHUR HOWARD WILLIAMS

(a) Residence. No. 416 West 35th St. St. 100 Ward. 100  
 (Usual place of abode) (If nonresident give city or town and State)

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

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF Alice McElroy Williams

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 10-1-1856

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
64 4 3

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Retired Contractor  
 (b) General nature of industry, business, or establishment in which employed (or employer).  
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) West Newbury  
 (STATE OR COUNTRY) Mass.

10. NAME OF FATHER Moses Williams

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Mrs. A. H. Williams  
 (Address) 416 W. 35th St., K.C.Mo.

15. FILED 76 23 M. M. Crowe  
 19 23 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-4-23 19 23

17. I HEREBY CERTIFY, That I attended deceased from Jan. 17, 1923, to Feb. 4, 1923.  
 that I last saw alive on Feb. 4, 1923, and that death occurred, on the date stated above, at 7-PM.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Bronchitis pneumonia  
probably due to influenza  
infection  
 (duration) yrs. mos. da. 20

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. da.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS? Symptoms  
 (Signed) L. G. Taylor, M. D.

Feb. 5, 19 23 (Address) 909 Waldheim Bldg

\*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, CREMATION, OR REMOVAL W. Washington DATE OF BURIAL 2-6-1923

20. UNDERTAKER Stine & McClure Co ADDRESS 904 Oak St.

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.

