

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

Do not use this space.

8396

**1. PLACE OF DEATH**

County..... Jackson Registration District No. .... 399  
 Township..... Itaw Primary Registration District No. .... 1002  
 City..... Itawanna City, Mo. Old City Hospital St. .... (Ward)

File No. .... 1250  
 Registered No. ....

**2. FULL NAME**

John W. Williams  
 (a) Residence. No. 228 Parallel 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 1869

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
58 - - - -

**8. OCCUPATION OF DECEASED**

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

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

PARENTS

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Lora Turner

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

14. INFORMANT Mrs. Alice Williams  
 (Address) 228 Parallel

15. FILED 3-25-27 W. B. Burton REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-20-1927

17. I HEREBY CERTIFY, That I attended deceased from 3-9, 1927, to 3-20, 1927 that I last saw him ~~alive~~ on 3-20, 1927, and that death occurred, on the date stated above, at 1:30 m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Hypostatic Pneumonia (Lobar)  
100%  
22-7

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

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH 228 Parallel

DID AN OPERATION PRECEDE DEATH? Yes DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical & Laboratory findings  
 (Signed) Howard M. Smith, M.D.  
3-20-1927 (Address) Old City Hospital

\*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL West Lawn Cemetery DATE OF BURIAL 3/25/27

20. UNDERTAKER W. B. Burton ADDRESS 1607 N. 8. West Kansas City

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.

WHILE IN USE, WITH UNFADING INK—THIS IS A PERMANENT RECORD

