

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

Do not use this space.

27700-2

JAN 3 1928

PLACE OF DEATH

County..... Lewis
Township..... Reddick
City..... Williamstown (No.)

Registration District No. 483
Primary Registration District No. 5644

File No.
Registered No.
St. Ward)

2. FULL NAME

William Thomas Louelle

(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. 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)

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.

4

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

10. NAME OF FATHER

Ed Louelle

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Lewis Co.

12. MAIDEN NAME OF MOTHER

Ada Ramus

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Clark Co.

14.

INFORMANT (Address)

Wm Louelle
Williamstown, Mo.

15.

FILED 12-3-1927

W. H. ...
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

9-1 1927

17.

I HEREBY CERTIFY, That I attended deceased from 8 24 1927, to 8 31 1927

that I last saw ~~him~~ her alive on 31st, 1927, and that death occurred, on the date stated above, at 2 9 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pharyngitis
MEMPHRIA
109 H
154
CONTRIBUTORY (SECONDARY)
(duration) yrs. mos. da.

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?

(Signed) Pat ..., M. D.

, 19 (Address) Centerville

*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

DATE OF BURIAL

St Patrick Mo 9-2 1927

20. UNDERTAKER

ADDRESS

Gersh & Backus Spokane Mo

Every item of information should be carefully supplied. It 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.

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.
 County Lewis Registration District No. 483 File No.
 Township Reddish Primary Registration District No. 5-644 Registered No.
 City (No.) St. Ward)

2. FULL NAME William Thomas Louille
 (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. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m
 4. COLOR OR RACE w
 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) 5-1-27

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

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) Lewis, Mo.
 (STATE OR COUNTRY)

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-1-27
 17. I HEREBY CERTIFY, That I attended deceased from
 to 19.....
 that I last saw him alive on 19....., and that
 death occurred, on the date stated above, at m.
 THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY)
 (duration) yrs. mos. ds.
 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)....., M. D.
 , 19 (Address)

*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 DATE OF BURIAL
 20. UNDERTAKER ADDRESS
 19

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 No dates W. Ford REGISTRAR

SUPPLEMENTARY

This was misphoned by doctor and did not get back to me as had to make a new one.

N. B.—Every item of information should be carefully supplied. Physicians should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. RARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

5-2740A