OCT 29 1927

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

Do not use this space.

1

File No. 20018

Registered No. 7698

1. PLACE OF DEATH

County: Vernon

Township:

City: Nevada (No. ..... St. ..... Ward)

Registration District No. 875

Primary Registration District No. 3039

2. FULL NAME Charles L. Williams

(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: 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: Jessie Williams.

6. DATE OF BIRTH (MONTH, DAY AND YEAR): 2/6/1857

7. AGE: Years 70 | Months 9 | Days 22 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Bookkeeper
(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): Ill

PARENTS

10. NAME OF FATHER: Wm Williams

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

12. MAIDEN NAME OF MOTHER: Ellen Posey

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

14. INFORMANT: Hospital Record
(Address): Hotel Hospital #3

15. FILED 10/8/1927 E. R. Hiser, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Sept. 29 1927

17. I HEREBY CERTIFY, That I attended deceased from April 19, 1927, to Sept. 29, 1927, that I last saw h alive on Sept. 29, 1927, and that death occurred, on the date stated above, at 7:25 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:—
Arteriosclerosis
S.I.D.
Hypertension 4 yr
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): Cerebral Hemorrhage
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? O.K.

DID AN OPERATION PRECEDE DEATH? No DATE OF .....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

Signed F. H. Drake, M. D.

Sept 30, 1927 (Address) Hotel Hospital #3

*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: Sedalia, Mo. | DATE OF BURIAL: Oct 1 1927

20. UNDERTAKER: Terry Funeral Home | ADDRESS: Nevada, Mo.

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.

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 Vernon — Registration District No. 875 — File No.

Township — Primary Registration District No. 3039 — Registered No. 168

City Nevada (No. , St. Ward)

2. FULL NAME Charles S. Williams

(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): M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec-6-1857

7. AGE: 1 — YEARS: 69 — MONTHS: 9 — DAYS: 23 — 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 11/10, 1927 E. R. Kiesg
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 29 1927

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

(duration) yrs. mos. ds.

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 19

20. UNDERTAKER — ADDRESS

SUPPLEMENTARY

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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