

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

Do not use this space.

36010

1. PLACE OF DEATH

County..... Buchanan
Township.....
City..... St. Joseph

Registration District No..... 85
Primary Registration District No..... 1001
State Hospital No. 2

File No.....
Registered No. 1248
St. _____ Ward)

2. FULL NAME

(a) Residence. No..... Unknown St. Ward. Unknown

(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 14 yrs. 4 mos. 19 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

Male | White | Single

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

about 1893

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

No record

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

34 | Unknown | — | —

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

None

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Missouri

PARENTS

10. NAME OF FATHER

M. F. Williams

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Illinois

12. MAIDEN NAME OF MOTHER

No record

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Michigan

14.

INFORMANT Record of State Hospital No. 2
(Address) St. Joseph, Mo.

15.

FILED 12/7/27 John G. W.
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) December 5, 1927

17. I HEREBY CERTIFY, That I attended deceased from November 1, 1927, to December 5, 1927, that I last saw him alive on December 5, 1927, and that death occurred, on the date stated above, at 9:50 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

85 Hemiplegia Rt. side
82 D.

CONTRIBUTORY (SECONDARY)

178 (duration) yrs. mos. 1 ds.
Epilepsy
(duration) 21 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? Chemical

(Signed) R. F. Crank, M. D.

Dec. 5, 1927 (Address) State Hospital, St. Joseph, 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

Kirkville, Missouri.

DATE OF BURIAL

Dec 8, 1927.

20. UNDERTAKER

M. D. Hidenfeder

ADDRESS

1802 Union Str

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.

