

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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

Do not use this space.

4984
644

1. PLACE OF DEATH

County *Polk*
Township *Howe*
City *Hausa, Mo.*

Registration District No. *32*
Primary Registration District No. *101*
No. *1235*

File No. *4984*
Registered No. *644*
St. _____ Ward _____

2. FULL NAME

Mellie Williams
(a) Residence. No. *614 18-13* 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 *F* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Widow*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *May 10 - 1861*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ____ hrs. or ____ min.
66 9 -

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work *none*
(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 Va*

10. NAME OF FATHER *Abiah Hatfield*

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

12. MAIDEN NAME OF MOTHER *Mary - Dennison*

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

14. INFORMANT (Address) *Stephen D Hatfield Galeburg Ill*

15. FILED *113 28* 19 *Mo* REGISTRAR *Wor*

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *2/10* 19 *28*

17. I HEREBY CERTIFY, That I attended deceased from *Jan 20* 19 *28* to *Feb 10* 19 *28* that I last saw her alive on *2-10-28* and that death occurred, on the date stated above, at *11:30* a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Bronchial Pneumonia
107A
1020 (duration) *100* yrs. mos. da.

CONTRIBUTORY (SECONDARY) *Asthma* (duration) *several yrs.*

18. WHERE WAS DISEASE CONTRACTED *Home*
IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? *No* DATE OF _____

WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS? *Sputum*
(Signed) *W. H. Head* M. D.
11 19 *28* (Address) *220 W 12th St. Ke 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 *Edenwood* DATE OF BURIAL *Feb. 14, 28*

20. UNDERTAKER *Mrs. C. L. Foster* ADDRESS *Kansas City*

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220-w-12

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