

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

Do not use this space.
Ernoway.
24409
File No. _____
Registered No. *68* _____
St. _____ Ward _____

1. PLACE OF DEATH
County *Macon* Registration District No. *533*
Township _____ Primary Registration District No. *3027*
City *Moberly* St. _____ Ward _____

2. FULL NAME *Lloyd B 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M.* 4. COLOR OR RACE *W.* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Married*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Dec 18, 1840*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<i>87</i>	<i>6</i>	<i>16</i>	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work *Pharmacist*
(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) *Scott Co, Mo.*

10. NAME OF FATHER *Geo Williams*

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

12. MAIDEN NAME OF MOTHER *Eliz. Benton*

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

14. INFORMANT *Mrs L B Williams*
(Address) *Moberly Mo.*

15. FILED *7/11* 19*28* *Mrs L B Williams*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *July 4 19 28*

17. I HEREBY CERTIFY That I attended deceased from *2-6* 19*28*, to *7-4* 19*28*
that I last saw h. *im* alive on *July 4, 1928*, and that death occurred, on the date stated above, at *8:30 p.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cardio-renal-vascular disease
131 (duration) *5 or more* yrs. mos. da.

CONTRIBUTORY (SECONDARY) *1290*

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

DID AN OPERATION PRECEDE DEATH. *W.E.* DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? *J.P. Jones* M.D.
7-5-28 (Address) *Moberly 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 DATE OF BURIAL
Oakwood Cemetery *7/6 19 28*

20. UNDERTAKER ADDRESS
Albert Skinner *Moberly*

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.

