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

Do not use this space.

29876-a

1. PLACE OF DEATH
County Butler — Registration District No. 825 — File No.
Township Ash Hill — Primary Registration District No. 5134C — Registered No. 27
City Fisk Mo (No. ..... St. ..... Ward)

2. FULL NAME Louie A. 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Married

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

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

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
50				

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farming
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Missouri
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER James Williams
11. BIRTHPLACE OF FATHER (CITY OR TOWN) U. S. A.
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Johnson
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) U. S. A.
(STATE OR COUNTRY)

14. INFORMANT Floyd Rescetter
(Address)

15. FILED 9 3rd 1928 Vincent L Greathouse
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9/3 1928

17. I HEREBY CERTIFY, That I attended deceased from 8-20, 1929, to 9-3-, 1928 that I last saw him alive on 9-3-, 1928 and that death occurred, on the date stated above, at 9-3-a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Heart trouble Cause from Stomach
95B (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) V. L. Greathouse, M. D
9/3, 1928 (Address) Fisk 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
Mole Hill	9-4 1928

20. UNDERTAKER	ADDRESS
J W Mourin	Fisk Mo

CAUSE OF DEATH: ...mation should be carefully ... should be stated EXACTLY. PHYSICIANS should state ... in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
County: Butler — Registration District No.: 925 — File No.:
Township: Ash Hill — Primary Registration District No.: 5134 e — Registered No.: 27
City: (No. , St. Ward)

2. FULL NAME Louie A. Williams

(a) Residence. No. St., Ward. (If nonresident give city or town and State)
(Usual place of abode)
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: Don't know the date of birth

6. DATE OF BIRTH (MONTH, DAY AND YEAR): 1879

7. AGE: About 50 — Years | Months | Days | 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 COUNTY)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTY)

14. INFORMANT
(Address)

15. FILED 9/3, 1928 — Vincent H. Greathouse, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 9 - 3 1928

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:
Chronic Heart trouble
Cause from stomach
Hard trouble with heart
(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

W. B.—Every item of information should be carefully supplied. ALL ANSWERS should be printed. EXTRA LINES should be used if necessary. Exact statement of OCCUPATIONS is very important.
CAUSE OF DEATH in medical terms, so that it may be [illegible]

REGISTRAR MAY RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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