

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

Do not use this space.

5679

1. PLACE OF DEATH

County Callaway Registration District No. 104
 Township Fulton Primary Registration District No. 3008
 City Fulton State STATE HOS. # 2 St. _____ Ward _____

File No. _____
 Registered No. 40

2. FULL NAME Viola Williams

(a) Residence. No. Pike Co Mo St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 7 yrs. 10 mos. 25 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 14 - 1891

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>37</u>	<u>2</u>	<u>25</u>	

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) Pike Co Mo

10. NAME OF FATHER J. M. Williams

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

12. MAIDEN NAME OF MOTHER Mrs. Thomas

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Howard Co Mo

14. INFORMANT State hospital records
 (Address) Fulton Mo

15. Feb 9 1929 R. N. Creed
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July - 9 - 1929

17. I HEREBY CERTIFY That I declared deceased from Oct. 7 - 1928 to July - 9 - 1929
 that I last saw h. or alive on July - 18 - 1929, and that death occurred, on the date stated above, at 7:50 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pulmonary Tuberculosis

CONTRIBUTOR Dementia Praecox
 (duration) _____ 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 Microscopic
 (Signed) H. Frazer M. D.

2-9-1929 (Address) Fulton 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 Bolingreen Mo DATE OF BURIAL 21 10 1929

20. UNDERTAKER Hendon - Taylor ADDRESS Fulton 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.

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PARENTS

