1929

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

Do not use this space.

11180

1. PLACE OF DEATH

County: Jasper — Registration District No.: 4111 — File No.:

Township: — Primary Registration District No.: 9002 — Registered No.: 118

City: Joplin (No. ..... St. ..... Ward)

2. FULL NAME Benjamin Franklin 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
M	W	Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Cassie R Williams

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Apr 24 1856

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
72				

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Miner 1249

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN): Arcola
(STATE OR COUNTRY): Ill

PARENTS

10. NAME OF FATHER: No Record

11. BIRTHPLACE OF FATHER (CITY OR TOWN): No Record
(STATE OR COUNTRY): No Record

12. MAIDEN NAME OF MOTHER: No Record

13. BIRTHPLACE OF MOTHER (CITY OR TOWN): No Record
(STATE OR COUNTRY)

14. INFORMANT: Sammie Williams
(Address): Galena Kansas

15. FILED 3-16 1929 Dr A B Clark, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): March 12 1929

17. I HEREBY CERTIFY, That I attended deceased from Feb 27, 1929, to Mch 10, 1929, that I last saw him alive on Mch 10, 1929, and that death occurred, on the date stated above, at 7-30 A.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cirrhosis of liver
also Hardening of Arteries
I only seen him twice.
(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? No DATE OF .....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) J L Truex, M. D.

, 19 (Address) Joplin 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
Oak Hill Cem	3-14 1929

20. UNDERTAKER	ADDRESS
Porter M Clark	Galena

Truex

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
County Jasper Registration District No. 411 File No.
Township Primary Registration District No. 2002 Registered No. 118
City Joplin (No. , St. Ward)

2. FULL NAME Benjamin F. 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)
M	W	M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr 26 - 1856

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
72	8	16	

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 COUNTRY)

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

14. INFORMANT
(Address)

15. FILED 5-20 1929 Dr A B Clark REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/12 1929

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:

(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

REG... ...E A FEE FOR CERTIFICATES UNTIL THEY ARE CO...LETE AS PRESCRIBED BY LAW

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