APR 26 1929

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

Do not use this space.

11448

1. PLACE OF DEATH
County Livingston Registration District No. 508 File No.
Township Primary Registration District No. 3026 Registered No. 50
City Chillicothe (Ward) St. Ward)

2. FULL NAME Dorthy Fay 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: 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) June 26-1916

7. AGE: 12 YEARS, 9 MONTHS, 5 DAYS. If LESS than 1 day, hrs. or min.

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) Grundy Co. Mo.

PARENTS
10. NAME OF FATHER W.H. Williams
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Ohio
12. MAIDEN NAME OF MOTHER Emma Davenport
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Grundy Co. Mo.

14. INFORMANT W.H. Williams
(Address) Chillicothe Mo

15. FILED 4/1 1929 Reuben Barney REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar-31-1929

17. I HEREBY CERTIFY, That I attended deceased from 18 Feb 1929, to Mar 31 1929 that I last saw her alive on Mar 31 1929, and that death occurred, on the date stated above, at 10:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Progressive muscular atrophy
(duration) several years yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 130
(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? Symptoms
(Signed) H. M. Grace, M. D
4/1 1929 (Address) Chillicothe 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: Alpha Cemetery
DATE OF BURIAL: 4-2 1929

20. UNDERTAKER: E. J. Robertson
ADDRESS: Laredo

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.