

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

Do not use this space.

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. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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N 24  
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9

1. PLACE OF DEATH  
 County Buchanan Registration District No. 85  
 Township St. Joseph Primary Registration District No. 1001  
 City Warrensburg (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Bell Williams  
 (a) Residence No. 1316-8, 20<sup>th</sup> St. St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode) (If nonresident give city or town and State)  
 Length of residence in city or town where death occurred unknown yrs. How long in U.S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

17319

File No. \_\_\_\_\_  
 Registered No. 617  
 St. \_\_\_\_\_ Ward \_\_\_\_\_

**PERSONAL AND STATISTICAL PARTICULARS**

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 29-1865

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>63</u>	<u>9</u>	<u>19</u>		

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

9. BIRTHPLACE (CITY OR TOWN) Holt Co -  
 (STATE OR COUNTRY)

10. NAME OF FATHER Thomas Glovers

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

12. MAIDEN NAME OF MOTHER Wm. Penner

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY)

14. INFORMANT Thomas W. Williams  
 (Address) 1316-B 20<sup>th</sup> St

15. FILED 7 1929 \_\_\_\_\_ 19\_\_\_\_  
John G. W. REGISTRAR

**2 MEDICAL CERTIFICATE OF DEATH**

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

17. I HEREBY CERTIFY, That I attended deceased from May 9-1929 to May 9-1929 that I last saw her alive on May 9 1929, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Apoplexy  
82A

CONTRIBUTORY (SECONDARY) Over work & Debility  
 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18. WHERE WAS DISEASE CONTRACTED \_\_\_\_\_  
 IF NOT AT PLACE OF DEATH \_\_\_\_\_

19. DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY? \_\_\_\_\_  
 WHAT TEST CONFIRMED DIAGNOSIS? Observation  
 (Signed) J. R. G. Carls, M. D.  
May 11 1929 (Address) 720 S 24<sup>th</sup>

\*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 <u>Ashland Cem</u>	DATE OF BURIAL <u>May 13 1929</u>
20. UNDERTAKER <u>B. F. Graves</u>	ADDRESS <u>806-S-17<sup>th</sup> St</u>

