

JUN 24 1929

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

Do not use this space.

17411

1. PLACE OF DEATH

County Butler
Township Nelly
City..... (No.....).....

Registration District No. 88
Primary Registration District No. 5130

File No.....
Registered No. 18
St. Ward)

2. FULL NAME

Alice Elena Williamson
(a) Residence. No. Nellyville Mo St. Ward.
(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

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Widow

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

Elijah Williamson

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

April 15 1857

7. AGE

YEARS MONTHS DAYS
72 00 18
If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer At home

9. BIRTHPLACE (CITY OR TOWN)

Rockfontas Arkansas
(STATE OR COUNTRY)

10. NAME OF FATHER

James Wilson

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Unknown Kentucky
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

Elenor Jordan

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Unknown
(STATE OR COUNTRY)

14.

INFORMANT Bessie Woodard
(Address) Nellyville, Mo

15.

FILED 5 3 1929 R. L. Turner
REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from Dec 2, 1928, to May 3, 1929, that I last saw h. alive on May 1, 1929, and that death occurred, on the date stated above, at 5:50 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Valvular heart disease namely Mitral Regurgitation
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99 A (duration) 87 yrs. 6 mos. - ds.
CONTRIBUTORY Chronic Nephritis
(SECONDARY) (duration) 2 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT IN PLACE OF DEATH.....

0 DID AN OPERATION PRECEDE DEATH..... NO. DATE OF.....

WAS THERE AN AUTOPSY..... NO

WHAT TEST CONFIRMED DIAGNOSIS..... Urinary

(Signed)..... R. L. Turner M. D.

, 19 (Address) Nellyville 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

Black Cemetery

DATE OF BURIAL

May 4 1929

20. UNDERTAKER

Friends & neighbors

ADDRESS

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.

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