

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

Do not use this space.

17888

1. PLACE OF DEATH

County Henry
Township X
City Windsor (No. _____)

Registration District No. 14
Primary Registration District No. 14211

File No. _____
Registered No. 18 St. _____ Ward _____

2. FULL NAME

Florus Drafer Williams
(a) Residence No. _____ St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred 25 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) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 1 - 1873

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
56 | 1 | 10

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 _____

9. BIRTHPLACE (CITY OR TOWN) Johnson
(STATE OR COUNTRY) Missouri

10. NAME OF FATHER M. C. Drafer

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

12. MAIDEN NAME OF MOTHER Marcia E. Fisher

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
(STATE OR COUNTRY) Kentucky

14. INFORMANT Mrs. W. W. Warren
(Address) Windsor, Mo.

15. May 13, 1929
FILED _____ REGISTRATION

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 10 19 29

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1928, to May 10 1929
that I last saw him alive on May 9 1929, and that death occurred, on the date stated above, at _____

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Brain Tumor
(Pituitary)
536
(duration) _____ yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

(duration) _____ yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, _____

1 DID AN OPERATION PRECEDE DEATH. yes DATE OF Feb 29

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Operation
(Signed) A. Amwall, M. D.

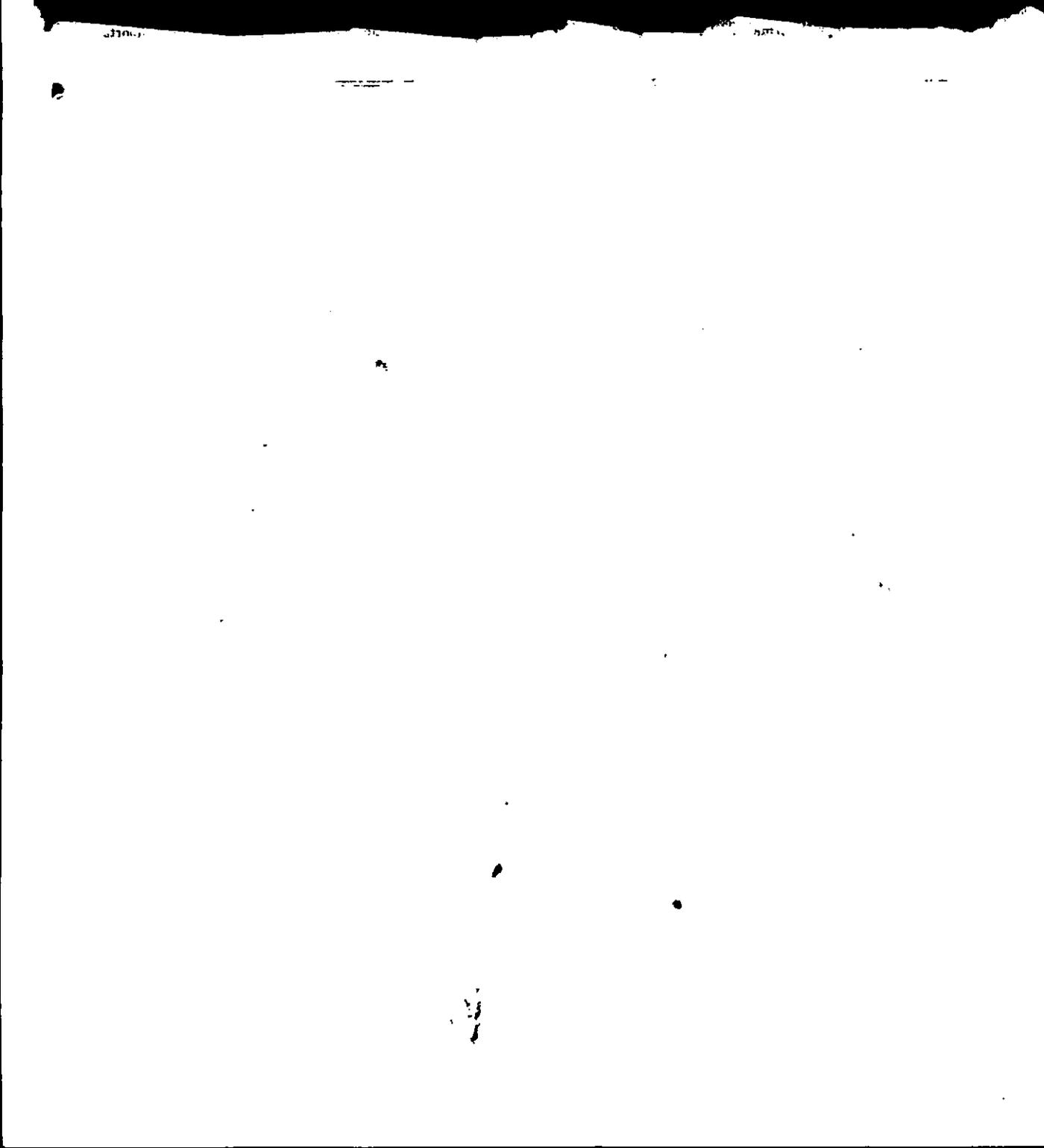
, 19 (Address) Windsor Mo.

*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

Windsor Mo DATE OF BURIAL May 12 1929

20. UNDERTAKER G. A. Peay ADDRESS Windsor Mo.



**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Henry

Registration District No. 14

File No. _____

Township _____

Primary Registration District No. 4211

Registered No. 18

City Windsor

(No. _____) St. _____

Ward _____

2. FULL NAME

Glorence Dwyer 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. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W

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

M

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

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

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, _____ hrs. or _____ min.

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)

FILED

1924

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 10. 1929

17. I HEREBY CERTIFY That I attended deceased from _____, 19____ to _____, 19____ that I last saw him _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Brain Tumor
Strabismic Squint
(duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY (SECONDARY) 49
(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____

DR. UNDERTAKER

ADDRESS

N. B.—Every item of information should be carefully checked. AGE should be stated EXACTLY. PHYSICIAN, if available, should be called. Every statement of OCCURRENCE is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

SUPPLEMENTARY

S-17888