OCT 29 1929

31

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

Do not use this space.

30430

1. PLACE OF DEATH

County Davies — Registration District No. 248 — File No.

Township Sheridan — Primary Registration District No. 5345 — Registered No. 13

City ..... (No. ..... St. ..... Ward)

2. FULL NAME Lois Pauline 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): ✓ ✓

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): July 11-1929

7. AGE: YEARS ✓ MONTHS 1 DAYS 24 — 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) Davies Co. Mo.

PARENTS

10. NAME OF FATHER: Bury Williams
11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Indiana
12. MAIDEN NAME OF MOTHER: Fatima Finley
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Mo.

14. INFORMANT: Fatima Williams (Address) Gallatin Mo.

15. FILED ..... 19..... Mrs Sam Smith REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Sept 5 — 1929

17. I HEREBY CERTIFY, That I attended deceased from July 11, 1929, to Sep. 5, 1929 that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at 1 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Inanition

158

160 (duration) ..... yrs. ..... mos. 54 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? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) M. A. Smith, M. D

Sep. 5, 1929 (Address) Gallatin 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: Creekmore — DATE OF BURIAL: 9/5 — 1929

20. UNDERTAKER: H A Hope — ADDRESS: Gallatin

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.