

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

Do not use this space.

33818
4270

1. PLACE OF DEATH

County Jackson
Township Kau
City St. C. Mo.

Registration District No. 399
Primary Registration District No. 1002

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

2. FULL NAME

Frederic Colburn Williams
(a) Residence No. 3221 Morrell St. _____ Ward _____
(Usual place of abode)

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 Male 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 Hellie Williams

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 16, 1858

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	70	11	30	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Clerk
(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) Mo. Va.

10. NAME OF FATHER John R. Williams

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT L. H. Williams
(Address) 3221 Morrell

15. FILED 10/15/29 M. M. Crowe REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct - 15 - 1929

17. I HEREBY CERTIFY, That I attended deceased from Sept 15, 1929 to Oct 15, 1929 that I last saw him... alive on Oct 15, 1929 and that death occurred, on the date stated above, at 4 p.m.

18. THE CAUSE OF DEATH* WAS AS FOLLOWS:
Carcinoma of Liver
46E
133C (duration) yrs. mos. 30 ds.
CONTRIBUTORY Suppression of Urine (SECONDARY) (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? Biopsy of Clinical symptoms
(Signed) William R. Jones M. D.
10/15, 1929 (Address) 626 Ludwig Bldg

*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 St. Washington DATE OF BURIAL Oct 17 1929

20. UNDERTAKER Mrs. C. L. Foster ADDRESS St. C. Mo.

N. E.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S STATEMENT OF CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important.

WHITE PAPER, WITH UNFADING INK—PRINTED AT THE MISSOURI STATE PRINTING PLANT, ST. LOUIS, MO.

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Dr. 500

~~4-5~~

2-4 at Rich. Beach

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County..... Registration District No. 399 File No.
Township..... Primary Registration District No. 1082 Registered No. 4270
City K. City (No.) St. Ward)

2. FULL NAME

(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 M 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 Grocery Clerk
(b) General nature of industry, business, or establishment in which employed (or employer) K. Grocery store
(c) Name of employer

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

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)

15.

FILED 10/15/29 M. M. Carove REGISTRAR
Ann

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 15 1929

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY)

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

20. UNDERTAKER

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 list CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

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