

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

Do not use this space.

11505

1. PLACE OF DEATH

County Wayne County Registration District No. 899
Township Blackriver Primary Registration District No. 6199
City (No. _____) St. _____ Ward _____

File No. _____
Registered No. 4
St. _____ Ward _____

2. FULL NAME Junie May Williams

(a) Residence No. Outway, Mo. 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. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 6 - 1921

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
8 | 9 | 4

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work School girl
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Wayne Co., Mo.
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER Abendego Williams
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Wayne Co. Mo.
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Lora Florence Moore
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Wayne Co. Mo.
(STATE OR COUNTRY)

14. INFORMANT Abendego Williams
(Address) Outway Mo.

15. FILED Mar 19 30 Mrs. Hattie McShae
REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 10 1930

17. I HEREBY CERTIFY, That I attended deceased from 11:00 A.M. Feb 23, 1930, to 12:31 P.M. Mar 9, 1930 that I last saw her alive on Mar 9, 1930, and that death occurred, on the date stated above, at 11:50 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Septicemia (staphylococci) general
109A
36
152B (duration) yrs. 2 mos. ds.

CONTRIBUTORY Pneumonia lobular
(SECONDARY) (duration) yrs. 10 ds.

18. WHERE WAS DISEASE CONTRACTED at place of death
IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? Yes DATE OF Feb 24 1930

20. WAS THERE AN AUTOPSY? No

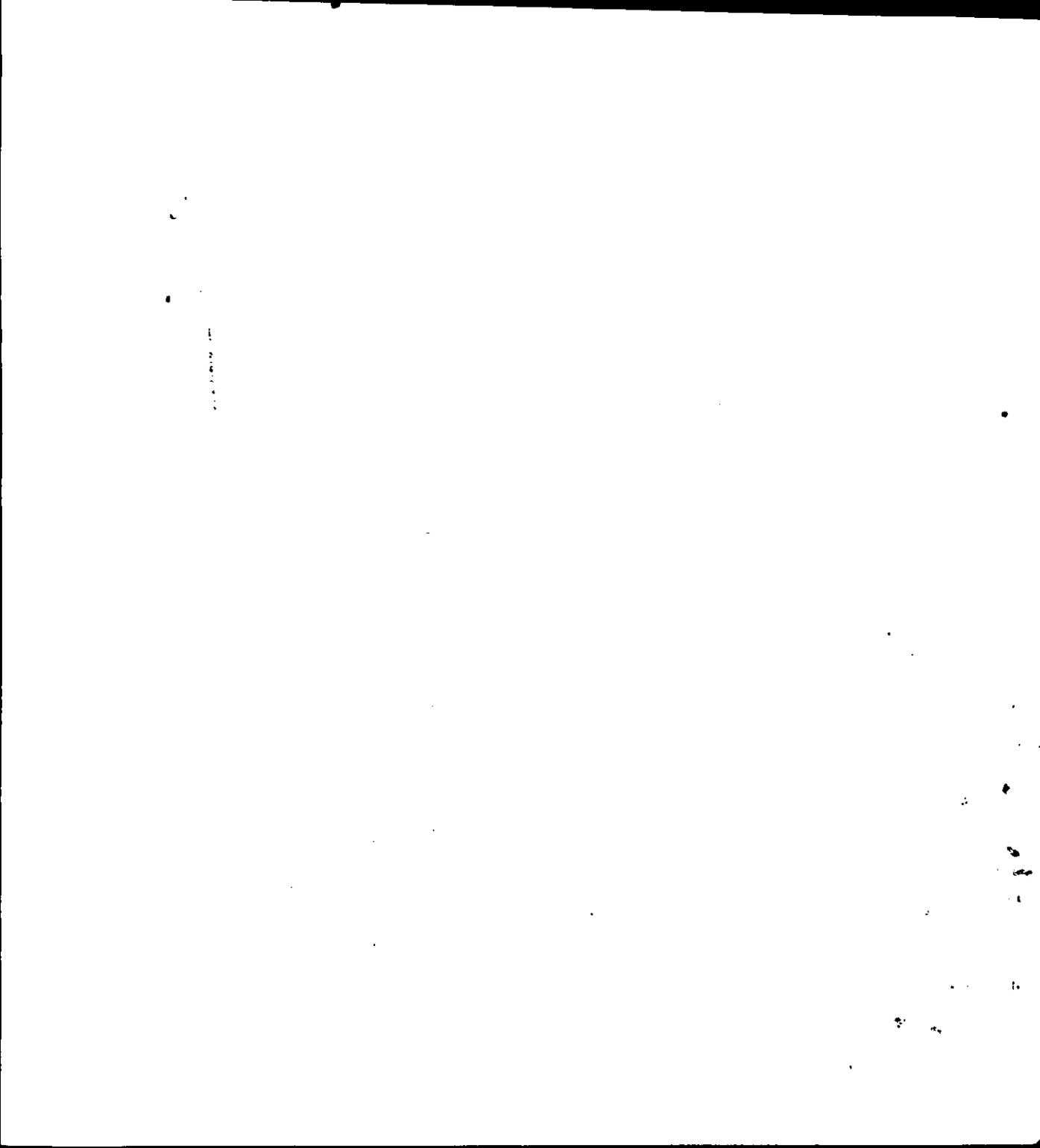
WHAT TEST CONFIRMED DIAGNOSIS (Smear of pus) (2 neg of chest)
(Signed) B. J. Macaulay M. D.
. 19 (Address) Poplar Bluff Mo

*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 Rucker Graveyard Wayne Co DATE OF BURIAL 3/11 1930

20. UNDERTAKER Alfred W. Grew ADDRESS Poplar Bluff Mo

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.



Name: Junie May Williams
Who died at: Wayne Co. on Mar. 10, 1930,

Residence; No. _____ St. _____
(If nonresident, city or town)
Length of residence in city or town where death occurred: Years _____ Months _____ Days _____

Sex: _____ Color or race: _____ Single, married, widowed or divorced: _____

Date of birth: _____ Age: Years _____ Months _____ Days _____

Occupation: (a) Trade _____ (b) Industry: _____

Birthplace (State or country) _____

Birthplace of father (State or country) _____

Birthplace of mother (State or country) _____

CAUSE OF DEATH: Septicemia (Staphylococci)
General.

Contributory: Lobular Pneumonia
Incision and drainage of multiple abscesses.

Where was disease contracted? _____

Did operation precede death? yes Date of _____

Was there an autopsy? _____ What test confirmed diagnosis? _____

Name of physician: B. J. Macaulay

Address of physician: Poplar Bluff Mo.

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