

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

Do not use this space.

12938

1. PLACE OF DEATH

County Jackson Registration District No. 399
 Township Richwood Primary Registration District No. 100
 City Richwood (No. 1403 E. 13th Str.) St. _____ Ward _____

File No. 1807
 Registered No. 1807

2. FULL NAME

Gertrude Williams
 (a) Residence No. 1403 E. 13th Str. St. 7 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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE negro 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 5-1892

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
38 1 23

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work House wife
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

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

10. NAME OF FATHER Edwin Everett

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

12. MAIDEN NAME OF MOTHER Alice Tolson

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

14. INFORMANT Mrs. Carrie Jones
 (Address) 3915 Loyd N.E. 1st

15. FILED 4/29 1930 M. M. Brown REGISTRAR
Arer

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-28-1930

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Hypertension
131
730 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Chronic Nephritis
Nephritis (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED 290
 IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

20. WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS Post Autopsy
 (Signed) P. W. Jones, M. D.

(Address) Deputy Comm
 *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 Maple Hill DATE OF BURIAL 5-12 1930

20. UNDERTAKER N. B. Emb & Hearst Co ADDRESS 470 State Ave N. B. Kansas

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.

