

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

Do not use this space.

13090

**1. PLACE OF DEATH**

County Jesserson  
Township Boasman  
City Crystal City

Registration District No. 421  
Primary Registration District No. 5575

File No. \_\_\_\_\_  
Registered No. 37  
St. \_\_\_\_\_ Ward) \_\_\_\_\_

**2. FULL NAME**

Neotato 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**

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**

Julia Williams

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

Oct 24 1856

**7. AGE**

YEARS	MONTHS	DAYS	If LESS than 1 day, ..... hrs. or ..... min.
<u>73</u>	<u>5</u>	<u>10</u>	

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work

Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

**9. BIRTHPLACE (CITY OR TOWN)**

Farmington Mo

(STATE OR COUNTRY)

**10. NAME OF FATHER**

Eliza Williams

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY)

**12. MAIDEN NAME OF MOTHER**

Elizabeth Bennett

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY)

**14.**

INFORMANT

(Address)

Mrs Bertha Williams  
Crystal City Mo

**15.**

FILED

44 1930 J. E. Rutledge  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** Apr. 3 1930

**17. I HEREBY CERTIFY, That I attended deceased from** Apr 3, 1930, to Apr 3, 1930, that I last saw him alive on Apr 3, 1930, and that death occurred, on the date stated above, at 12-10 P. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Cerebral Hemorrhage

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

**CONTRIBUTORY (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

(Signed) J. Hornell, M. D.

(Address) Crystal City 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**

**DATE OF BURIAL**

Samuel Cemetery 4/6 1930

**20. UNDERTAKER**

**ADDRESS**

Link Land, O. Festus 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.

