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

Do not use this space.

28943

1. PLACE OF DEATH
County Vernon — Registration District No. 880
Township Walker — Primary Registration District No. 4533
City Walker (No. ..... St. ..... Ward)

File No. .....
Registered No. 17

2. FULL NAME Barbara Ann Williams
(a) Residence. No. Marvin Ave St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 24 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): Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF H.H. Williams (Deceased) Widowed

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 26th 1853

7. AGE: Years 77 — Months 5 — Days 3 — If LESS than 1 day, ... hrs. or ..... min.

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) .....
(STATE OR COUNTRY) Indiana

PARENTS
10. NAME OF FATHER Joab Denorbit Moore
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Indiana
12. MAIDEN NAME OF MOTHER Barbara Ann Moore
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Indiana

14. INFORMANT Miss Lena Williams
(Address) Walker Mo

15. FILED 8/30 1930 C. B. Davis REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) August 29 1930

17. I HEREBY CERTIFY, That I attended deceased from July 10, 1930, to Aug 28, 1930 that I last saw her alive on Aug 28, 1930, and that death occurred, on the date stated above, at 3 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Tuberculosis of Lungs
2 ...
(duration) 8 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? Clinical
(Signed) C B Davis, M.D
8/30 1930 (Address) Walker 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: Mt Vernon Cemetery — DATE OF BURIAL: 9/4 1930

20. UNDERTAKER: Ferry Bros — ADDRESS: Nevada 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.