OCT 31 1930

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

Do not use this space.

30935

File No. 148

Registered No.

1. PLACE OF DEATH

County St Francois — Registration District No. 994

Township St Francois — Primary Registration District No. 6018B

City Flat River (No. ..... St. ..... Ward)

2. FULL NAME Edna May 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: F

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Child

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Dec 23-1929

7. AGE — YEARS: — MONTHS: 9 — DAYS: 1 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: none

(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): Flat River Mo.

PARENTS

10. NAME OF FATHER: Theo. Williams

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Flat River Mo

12. MAIDEN NAME OF MOTHER: Florence Robison

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Washington Co Mo

14. INFORMANT: Theo. Williams
(Address): Flat River Mo

15. FILED Sept 30, 1930 W J Bryan REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 9-24 1930

17. I HEREBY CERTIFY, That I attended deceased from Sept 21, 1930, to Sept 23, 1930 that I last saw her alive on Sept 23, 1930, and that death occurred, on the date stated above, at 2:00 A.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Ileo-colitis

10 D

10 D (duration) yrs. mos. 5 ds.

CONTRIBUTORY (SECONDARY): Broncho pneumonia

(duration) yrs. mos. 2 ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? D. K

DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) W. J. Bryan, M. D

9/25, 1930 (Address) Flat River 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: Wood Lawn Cemetery — DATE OF BURIAL: 9/25 1930

20. UNDERTAKER: Raymond Caldwell — ADDRESS: Flat River 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.