

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

Do not use this space.

**39765**

**PLACE OF DEATH**

County Jasper

Township Carthage

City Carthage

Registration District No. 408

Primary Registration District No. 3020

File No. ....

Registered No. ....

St. .... Ward)

**2. FULL NAME** Fern Hazel Williams

(a) Residence. No. 214 McCreagh St. .... Ward. (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 1 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)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 28 - 1905

7. AGE (in) YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min.  
25 2 1

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work. at home  
(b) General nature of industry, business, or establishment in which employed (or employer).  
(c) Name of employer

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

10. NAME OF FATHER R. A. Albrook

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

12. MAIDEN NAME OF MOTHER Susan Vinick

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

14. INFORMANT Ray Williams  
(Address) Carthage Mo

15. FILED 12/27, 1930 E. D. McPherson  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 26 1930

17. I HEREBY CERTIFY, That I attended deceased from Dec 12, 1930, to Dec 26, 1930, that I last saw him alive on Dec 22, 1930, and that death occurred, on the date stated above, at 3 9 a.m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

chr Pulmonary Tuberculosis  
29A

**CONTRIBUTORY (SECONDARY)**

18. WHERE WAS DISEASE CONTRACTED none  
IF NOT AT PLACE OF DEATH   
DATE OF no

19. WAS THERE AN AUTOPSY? no

20. WHAT TEST CONFIRMED DIAGNOSIS? Lat & gen physical  
(Signed) A. A. LaRue, M. D.  
(Address) Carthage 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.

21. PLACE OF BURIAL, CREMATION, OR REMOVAL Lynn Mo

22. DATE OF BURIAL 12/27 1930

23. UNDERTAKER W. H. City Und Co

24. ADDRESS W. H. City

WRITE PLAINLY, WITH OBLIQUE INK--- THIS IS A PERMANENT RECORD

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.

