MAR 23 [redacted]

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

Do not use this space.

4643

1. PLACE OF DEATH
11 County Buchanan — Registration District No. 85 — File No.
5 Township — Primary Registration District No. 1001 — Registered No. 164
9 City St Joseph (No. State Hospital #2 St. Ward)

2. FULL NAME Ella Williams
(a) Residence. No. State Hospital St., Ward. Kansas City, Mo.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. 6 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: Negro
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): No Facts (?)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: No Facts

6. DATE OF BIRTH (MONTH, DAY AND YEAR): about 1861

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
70	No Facts	No Facts	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: No Facts
(b) General nature of industry, business, or establishment in which employed (or employer): No Facts
(c) Name of employer: No Facts

9. BIRTHPLACE (CITY OR TOWN): No Facts
(STATE OR COUNTRY): No Facts 31

PARENTS
10. NAME OF FATHER: No Facts
11. BIRTHPLACE OF FATHER (CITY OR TOWN): No Facts
(STATE OR COUNTRY): No Facts
12. MAIDEN NAME OF MOTHER: No Facts
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): No Facts
(STATE OR COUNTRY): " "

14. INFORMANT: Hosp. records
(Address) St Joseph Mo

15. FILED FEB 12 1931, 19 John R. Bender REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3

16. DATE OF DEATH (MONTH, DAY AND YEAR): Feb. 11th 1931

17. I HEREBY CERTIFY, That I attended deceased from Aug. 9th, 1930, to Feb. 11th, 1931 that I last saw her alive on Feb. 10th, 1931, and that death occurred, on the date stated above, at 7:30 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
General Paralysis of the Insane
83
34
162 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY): Syphilis & Senility
(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 & Lab.
(Signed) C. O. Dewey, M. D.
2/11/31 (Address) State Hosp. No 2

*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: Asylum Cemetery — DATE OF BURIAL: Feb 12th 1931

20. UNDERTAKER: Ramsey Funeral Service — ADDRESS: 9th & Olive

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD