

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

Do not use this space.

28430

1. PLACE OF DEATH

County Jackson Registration District No. 38
 Township Raw Primary Registration District No. 100
 City K.C. Mo. (No. Mercy Hospital) St. Mo. Ward 3558

2. FULL NAME

Donald O. Williams
 (a) Residence. No. Teresita, Mo. St. Mo. Ward X Teresita, Mo.
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>male</u>	4. COLOR OR RACE <u>Wh</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Child</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Sept-8-1920</u>				
7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
		<u>11</u>	<u>14</u>	
8. OCCUPATION OF DECEASED				
(a) Trade, profession, or particular kind of work <u>Child</u>				
(b) General nature of industry, business, or establishment in which employed (or employer) <u>none</u>				
(c) Name of employer _____				

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8/22/31 1931

17. I HEREBY CERTIFY, That I attended deceased from 8/22/31, 1931, to 8/22/31, 1931, that I last saw h. alive on 8/22/31, 1931, and that death occurred, on the date stated above, at 5:05 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

acute
osteomyelitis of Lt. os Calcanei
154
133 1/2
 (duration) yrs. mos. 10-14 ds.
 CONTRIBUTORY (SECONDARY) multiple lung abscesses
multiple kidney abscesses
chronic fibrinous pericarditis
 (duration) yrs. mos. ds.
non-tuberculous

18. WHERE WAS DISEASE CONTRACTED
NOT AT PLACE OF DEATH athome

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? ye

WHAT TEST CONFIRMED DIAGNOSIS? Gram - Stab + autopsy

(Signed) W M Howard M. D.

8/22/31 (Address) Mercy Hosp

*State the DISEASE CAUSING DEATH, or in death from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Mo.

PARENTS

10. NAME OF FATHER Bunk Williams

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

12. MAIDEN NAME OF MOTHER Altha Leather

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

14. INFORMANT Bunk Williams
 (Address) Merriman, Ky. R.#1

15. FILED 8/23 1931 M. M. Crowe
 REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Mountain View, Mo. DATE OF BURIAL 8-24-1931

20. UNDERTAKER Mrs. C. L. Foster ADDRESS K.C. 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.

WRITE PLAINLY, WITH CLARITY

