

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

Do not use this space.

21721

1. PLACE OF DEATH
 105 County Sullivan Registration District No. 849 File No. _____
 Township Buchanan Primary Registration District No. 6123 Registered No. 3
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME James 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single
 5A. IF MARRIED, WIDOWED OR DIVORCED HUSBAND OF (OR) WIFE OF Lou Drinker Williams
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) 8, 7 1848
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
83 10 ?
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work day laborer
 (b) General nature of industry, business, or establishment in which employed (or employer) on farm
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) Mo.
 10. NAME OF FATHER James Williams
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Ky.
 12. MAIDEN NAME OF MOTHER Linda Bybee
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Mo.

14. INFORMANT Mrs. Mont Murphy (Address) Green City Mo.
 15. FILED June 19 32 Miss Kate Lane REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3
 16. DATE OF DEATH (MONTH, DAY AND YEAR) June 12 19 32
 17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Possibly Apoplexy or Heart failure. Did not receive medical aid could reach there.
 (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) Age & Debility
 (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____ (5)
 IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH? no DATE OF _____
 WAS THERE AN AUTOPSY? no
 WHAT TEST CONFIRMED DIAGNOSIS? History of disease.
 (Signed) J. C. Roberts, M.D. M.D.
 , 19____ (Address) Pollock, 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 Green City Cem. DATE OF BURIAL June 13 19 32
 20. UNDERTAKER Glenn E Kent ADDRESS Green City 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.

JUN 27 1932

