

WRITE PLAINLY, WITH UNFADING 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.

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

FREEHEAN
Do not use this space.
✓ 20131
File No. 290
Registered No. _____
St. _____ Ward _____

1. PLACE OF DEATH Greene
 County Greene Registration District No. 318
 Township Springfield Primary Registration District No. 2001
 City Springfield (No. 2015 n. Newton) St. _____ Ward _____
 2. FULL NAME Adrian J. Williams
 (a) Residence, No. 2015 n. Newton 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) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Martha J. Williams

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 4 - 1885

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>79</u>	<u>2</u>	<u>20</u>	

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Retired Minister

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Church Work

10. Date deceased last worked at this occupation (month and year) 20 yrago. 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ill

13. NAME Isby Williams

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn

15. MAIDEN NAME Beer

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT (ADDRESS) Martha J. Williams
Springfield, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Walden DATE 6-26 1934

19. UNDERTAKER (ADDRESS) W. H. Ingley & Co
Springfield, Mo.

20. FILED 6-25 1934 John Williams Registrar

3 MEDICAL CERTIFICATE OF DEATH

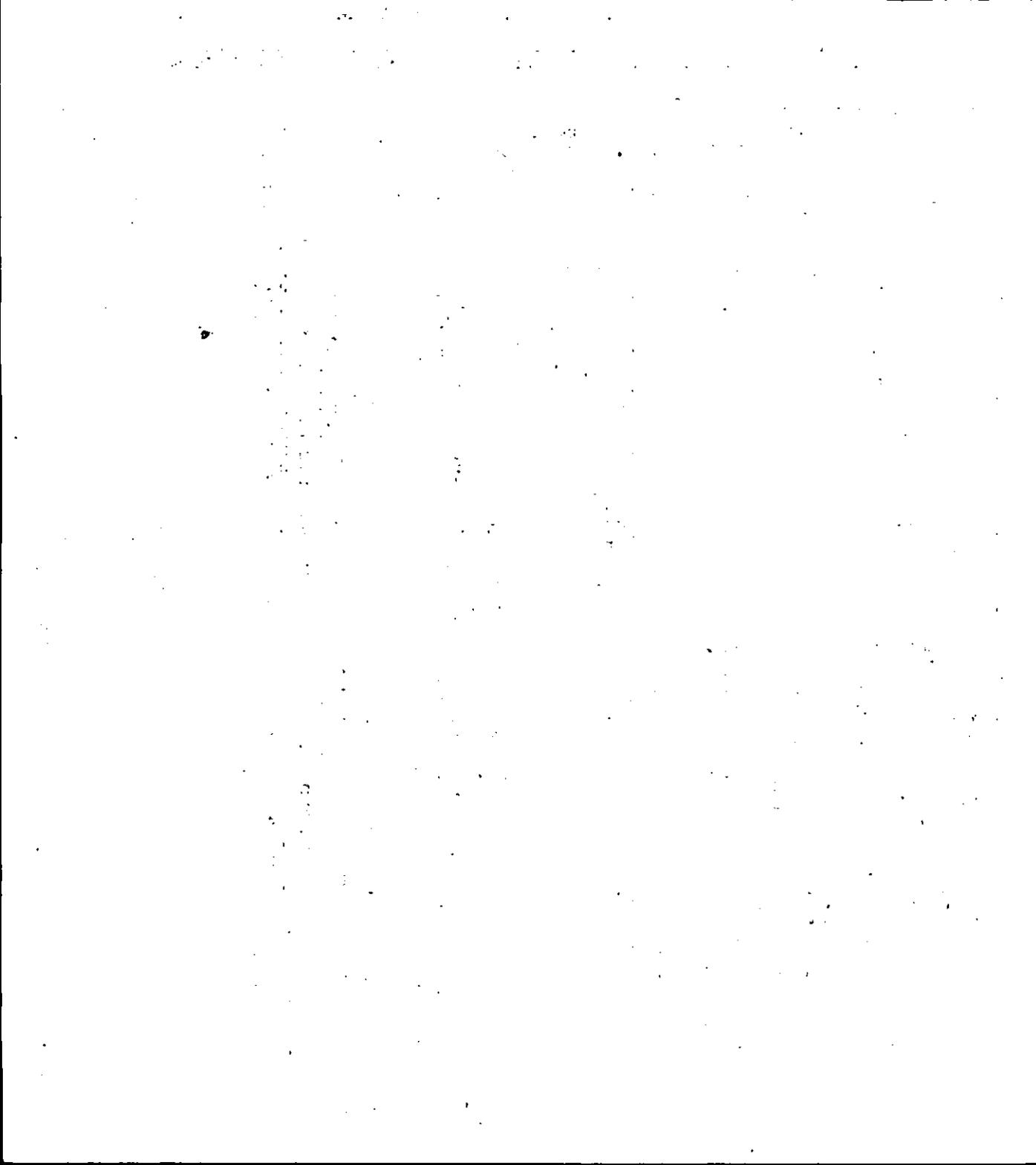
21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 24 - 1934

22. I HEREBY CERTIFY That I attended deceased from 6/14 1934 to 6/24 1934
 I last saw him alive on 6/23 1934 Death is said to have occurred on the date stated above, at 11:25 p.m.
 The principal cause of death and related causes of importance were as follows:
Senility
82A
115A
160
 Other contributory causes of importance:
partial paralysis of muscles of throat
 Name of operation none Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury None
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?
 If so, specify _____
 (Signed) J. J. Ferguson M. D.
 (Address) Springfield, Mo.



Greene

WASHINGTON *20131*

290

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: *Aldran G. Williams*
Who died at _____ on *June 24 / 1934*
Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____
Sex *M* Color or race *W* Single, married, widowed or divorced: _____

Date of birth _____ Age: Years *79* Months *2* Days *20*

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. (b) Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Date deceased last worked at this occupation: Month _____ Year _____
Birthplace (State or country) *of muscles of throat*
Birthplace of father (State or country) _____
Birthplace of mother (State or country) *Cerebral Hemorrhage*
Principal cause of death: _____

Other contributory causes of importance _____
Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____
If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19 _____
Where did injury occur? _____
(Specify city or town, county and State).

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____
Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
Name of physician *J. F. Greener - Springfield Mo.*
Address of physician _____
Signature of Registrar *John Williams* Date filed *10/29/34*

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Very truly yours,
E. T. McLaugh
State Registrar

Reg. Dist. No. *318*
Primary Reg. Dist. No. *2001*

Special Agent.

STATE OF NEW YORK
OFFICE OF THE ATTORNEY GENERAL
ALBANY, N. Y.

S-20131

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