

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

Do not use this space.

24068

1. PLACE OF DEATH

County Gentry Registration District No. 309
Township Athens Primary Registration District No. 5427
City (No.)

File No. _____
Registered No. 446 -
St. 222 Ward

2. FULL NAME Oria Along 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 <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Barna E. McNeese</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Dec. 24 1860</u>		
7. AGE YEARS <u>73</u>	MONTHS <u>7</u>	DAYS <u>20</u>
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Farmer</u>		11. Total time (years) spent in this occupation
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.		
10. Date deceased last worked at this occupation (month and year)		

3 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 14 1934

22. I HEREBY CERTIFY That I attended deceased from 2-12 1934, to 7-14 1934
I last saw him alive on 14 - July, 1934. Death is said to have occurred on the date stated above, at 7 P. M.
The principal cause of death and related causes of importance were as follows:
Cerebral Embolism
Mural Thrombosis
Myocarditis

Date of onset 7-10-34

Other contributory causes of importance:
none

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

MOTHER FATHER

13. NAME Thomas Williams

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

15. MAIDEN NAME Moberly

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

17. INFORMANT Curtis Williams
(ADDRESS) St. Joe Mo

18. BURIAL, CREMATION, OR REMOVAL
PLACE Lone Star DATE July 16, 1934

19. UNDERTAKER A. J. Bagg
(ADDRESS) Albany Mo.

20. FILED July 30, 1934 W. P. M. J. H. H.
Registrar.

Name of operation none Date of _____

What test confirmed diagnosis? clin. Was there an autopsy? no

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 _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify _____
(Signed) Frank H. Rose, M. D.
(Address) Albany, Mo.

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.

AUG 16 1934

