

JUN 3 1935

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

Do not use this space.

14003

1. PLACE OF DEATH

County Randolph
Township.....
City Moberly (No)

Registration District No. 735
Primary Registration District No. 3034

File No.....
Registered No. 80
St. Ward)

2. FULL NAME

(a) Residence, No. 801 S. Moulton St. Ward.....
(Usual place of abode)

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE col. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 13/1934

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
4

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.....
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).....
11. Total time (years) spent in this occupation.....

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

FATHER
13. NAME Frank Williams

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

MOTHER
15. MAIDEN NAME Mitchell Williams

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

17. INFORMANT (ADDRESS) Mitchell Williams 801 S. Moulton

18. BURIAL, CREMATION, OR REMOVAL PLACE Moberly Mo. DATE Apr 13, 1935

19. UNDERTAKER (ADDRESS) Robert L. Carr Moberly Mo.

20. FILED 4/12, 1935 Regina Walker Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 12, 1935

22. I HEREBY CERTIFY, That I attended deceased from Apr. 11, 1935 to Apr. 12, 1935

I last saw him alive on Apr. 11, 1935 Death is said

to have occurred on the date stated above, at 6 A. m.

The principal cause of death and related causes of importance were as follows:

Broncho-Pneumonia Date of onset

Other contributory causes of importance:

Name of operation..... 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.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify.....

(Signed) H.A. Pender M. D.

(Address) Moberly Mo.

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

Do not use this space.

1. PLACE OF DEATH

County Randolph
Township _____
City Moberly (No. _____)

Registration District No. 736-
Primary Registration District No. 3034

File No. _____
Registered No. 80
St. _____ Ward _____

2. FULL NAME

Robert Lee 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>m</u>	4. COLOR OR RACE <u>col</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)				
7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.		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)		
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)				
13. NAME				
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)				
15. MAIDEN NAME				
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)				
17. INFORMANT (ADDRESS)				
18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19__				
19. UNDERTAKER (ADDRESS)				
20. FILED <u>7/1</u> 19 <u>35</u> <u>Virginia Walker</u> Registrar (Address) _____				

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr 12 1935

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____.

I last saw h. _____ alive on 4 _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:
Broncho pneumonia Date of onset _____

No history of measles or whooping cough prior to the pneumonia.

Other contributory causes of importance: _____

Name of operation _____ 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 _____
Nature of injury _____

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

SUPPLEMENTAL

1070

JUN 15 1935

S-14003

