

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

Do not use this space.

16280

1. PLACE OF DEATH **JUN 21 1935**

County **Holt**
Township **Forest**
City **Forest City** (No.)

Registration District No. **370**
Primary Registration District No. **4216**

File No.
Registered No. **6**
St. Ward)

2. FULL NAME **James Redmond 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) **widowed**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Nov. 1- 1853**

7. AGE YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
81	6	8	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **Retired farmer.**
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) **Mexico Mo.**
(STATE OR COUNTRY)

10. NAME OF FATHER **Thomas Williams**

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT **Mrs. Bertha Beavers**
(Address) **Forest City Mo.**

15. FILED **May 9, 1935** **F O Buller**
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **May 9, 1935** 19

17. I HEREBY CERTIFY, That I attended deceased from **May 7- 1935**, 19, to **May 9- 1935**, 19, that I last saw him alive on **May-9 1935**, 19, and that death occurred, on the date stated above, at **12/ 15 P.M.** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic interstitial nephritis

Several years (duration) yrs. mos. ds.

CONTRIBUTORY **Chronic valvular disease**
(SECONDARY) **of heart**

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? **no** DATE OF

WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS **clinical**
(Signed) **F O Buller** M. D.

, 19 (Address) **Forest City 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 DATE OF BURIAL

Bethany, Mo

May 10 1935

20. UNDERTAKER

Joe Wheeler

ADDRESS

Bethany, 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.

