

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.

APR 23 1936

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

Do not use this space.

*Dyer*  
11877

1. PLACE OF DEATH

County *Pettis*

Registration District No. *668*

Township *Sedalia*

Primary Registration District No. *3032*

City *Sedalia*

(No. *Bothwell Hospital*)

File No. *18*

Registered No. *668*

St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

*D. D. Williams*

(a) Residence, No. *Cross Timbers Mo. 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

*M*

4. COLOR OR RACE

*W*

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

*Married*

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

*Lillian Williams*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

*About 1870*

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

*66 about*

OCCUPATION

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

*Farmer*

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)

*Benton Co Mo*

FATHER

13. NAME

*Do not know*

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

MOTHER

15. MAIDEN NAME

*Do not know*

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

17. INFORMANT (ADDRESS)

*Mrs Lillian Williams Cross Timbers*

18. BURIAL, CREMATION, OR REMOVAL

PLACE *Cross Timbers* DATE *3/5/36*

19. UNDERTAKER (ADDRESS)

*J. P. Luckey Joplin Mo*

20. FILED

*3/5/36 Jean Slack*

Registrar.

MEDICAL CERTIFICATE OF DEATH

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

*Mar 2 1936*

22. I HEREBY CERTIFY, That I attended deceased from

*2/2 1936* to *3/2 1936*

I last saw him alive on *3/1 1936* Death is said

to have occurred on the date stated above, at *2 A. m.*

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

Date of onset

*Hypostatic pneumonia 2/29*

Other contributory causes of importance:

*Gall Stones*

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) *D. D. Dyer*, M. D.

(Address) *Sedalia Mo*

