SEP 29 1936

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

Do not use this space.

31231

1. PLACE OF DEATH
County Jackson — Registration District No. 399 — File No.
Township Fair — Primary Registration District No. 1002 — Registered No.
City K.C. Mo. (No. General Hosp. #2 St. 2nd Ward)

2. FULL NAME Walter Williams
(a) Residence, No. 528 Missouri 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 Colored
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 8-13-1865
7. AGE YEARS 71 MONTHS — DAYS 15 If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. None
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) Ark.

FATHER
13. NAME Deceased
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS) Record Clerk
18. BURIAL, CREMATION, OR REMOVAL
PLACE Lids Mo DATE 9-1-36
19. UNDERTAKER (ADDRESS) H.B. Moore 1820 E. 18th St.
20. FILED 8-31, 1936 M. M. Crowe, asst. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-28, 1936
22. I HEREBY CERTIFY, That I attended deceased from 8-25, 1936 to 8-28, 1936
I last saw him alive on 8-28, 1936. Death is said to have occurred on the date stated above, at 10:00 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:
Senility

Name of operation ..... Date of ..... Yes
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? No
If so, specify .....
(Signed) [signature] M.D.
(Address) General Hosp. #2

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.