APR 28 1937

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

Do not use this space.

1. PLACE OF DEATH

County Staddard — Registration District No. 838 6

Township Liberty — Primary Registration District No. 4509

City ..... (No. ..... St. ..... Ward)

File No. 13851

Registered No. .....

2. FULL NAME Carlton 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): Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Jan. 16, 1937

7. AGE — YEARS: — MONTHS: 2 — DAYS: — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Clarkton Mo
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Chester Williams

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

12. MAIDEN NAME OF MOTHER Nancy Bates

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

14. INFORMANT Abraham Bates
(Address) Gideon, Mo

15. FILED 4/7 1937 Margaret Boone Registrar
Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 11 1937

17. I HEREBY CERTIFY, That I attended deceased from Feb 9, 1937, to Feb 11, 1937 that I last saw him alive on Feb 9, 1937, and that death occurred, on the date stated above, at 1.30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pleuro Pneumonia
lobar

(duration) 10 8 yrs. mos. 3 ds.

CONTRIBUTORY (SECONDARY) .....

(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? At home

DID AN OPERATION PRECEDE DEATH? No DATE OF .....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Phys. Exam

(Signed) W. L. Dickman, M. D

, 19 (Address) Dexter 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: Molehill Cem. Butler Co.

DATE OF BURIAL: 2-11 1937

20. UNDERTAKER: None

ADDRESS

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.