

AUG 23 1937

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

Do not use this space.

1. PLACE OF DEATH

County *Henry*Township *Miller*

City

(No.)

Registration District No. *313 543*Primary Registration District No. *47-89*File No. *27197*

Registered No.

St.

Ward)

2. FULL NAME *Martina B Williams*

(a) Residence, No.

(Usual place of abode)

St.

Ward.

(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

Female

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

J. W. Williams died

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

Sept 14 - 1861

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

*75**5**22*

8. OCCUPATION OF DECEASED

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

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

Housekeeper

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

Mo.

(STATE OR COUNTRY)

10. NAME OF FATHER

Martin Groom

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Mo.

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

Elizabeth Poage

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Mo.

(STATE OR COUNTRY)

14. INFORMANT

Rufus Williams

(Address)

Mc Fall Mo

15. FILED

*Mar 8 1937**W. P. [Signature]*

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *March 6 1937*

17.

I HEREBY CERTIFY, That I attended deceased from *Feb 26* ~~March 7~~ *1937* to *March 7 1937* that I last saw him alive on *March 6 1937* and that death occurred, on the date stated above, at *2* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY? *NO*

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) *J. H. Baizer* M. D.

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(Address) *Albany 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

*Mc Fall Mo**Mar 8 1937*

20. UNDERTAKER

ADDRESS

G. S. Groom Pattersonburg 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.

