

SEP 21 1937

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

Do not use this space.

1. PLACE OF DEATH

County Macon  
Township Macon  
City Macon (No. ...., St. .... Ward)

Registration District No. 533  
Primary Registration District No. 3027

File No. 31168  
Registered No. 70

2. FULL NAME

(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

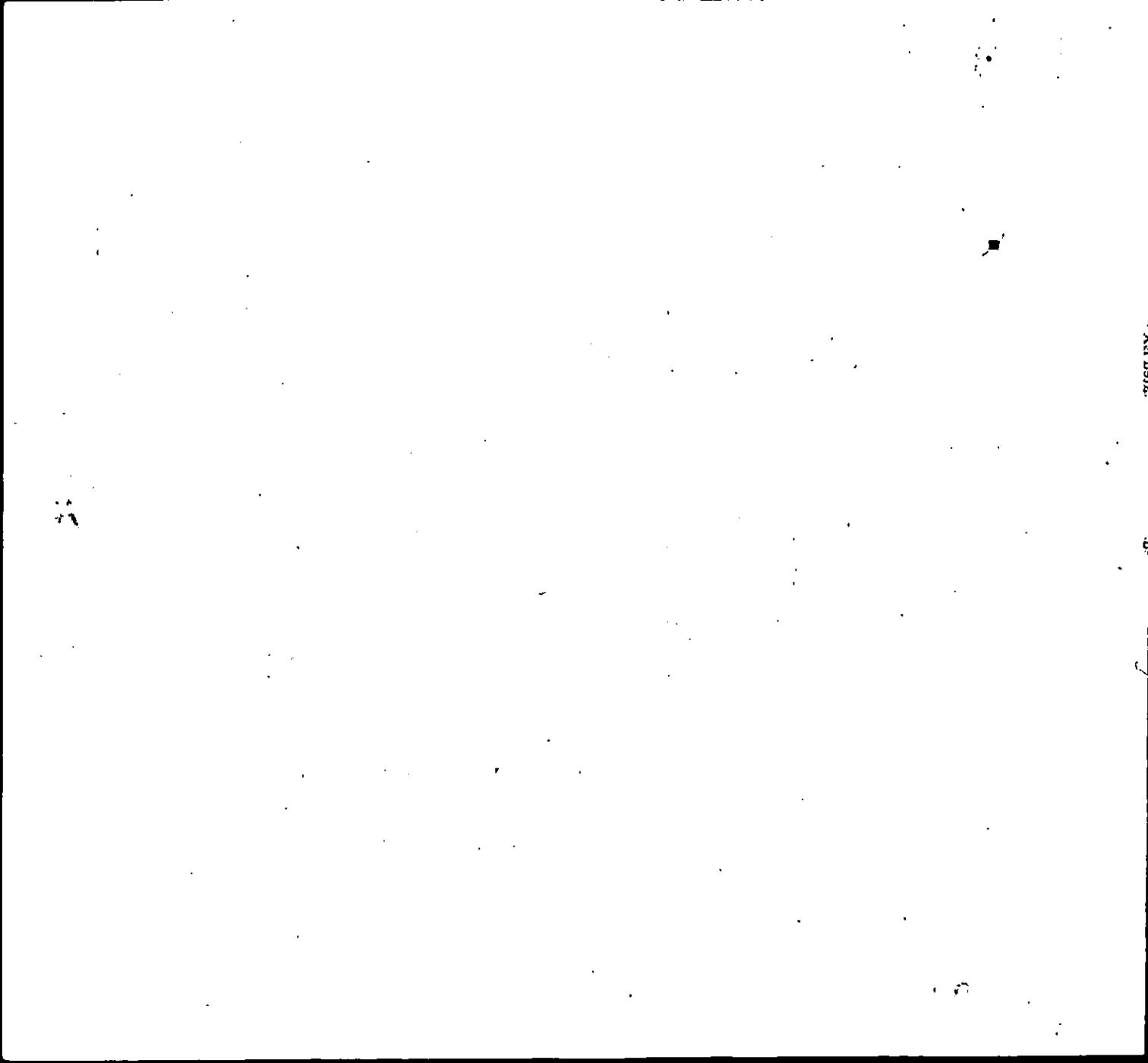
3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 26 - 1873  
7. AGE YEARS 63 MONTHS 10 DAYS 15 If LESS than 1 day, .... hrs. or .... min.  
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Sabour  
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) Missouri  
13. NAME John Williamson  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ky  
15. MAIDEN NAME Martha Ball  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Virginia  
17. INFORMANT Mrs J T Williamson (ADDRESS) Macon Mo  
18. BURIAL, CREMATION, OR REMOVAL PLACE Clarence Mo DATE Aug 13, 1937  
19. UNDERTAKER Robert S. Keenan (ADDRESS) Macon Mo  
20. FILED 9/11 1937 Leola Keenan Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 12 . 1937  
22. I HEREBY CERTIFY, That I attended deceased from Aug 1937 to Aug 12 1937  
I last saw him alive on Aug 10 1937 Death is said to have occurred on the date stated above, at 6:30 a.m.  
The principal cause of death and related causes of importance, were as follows:  
Cerebral Apoplexy Date of onset Aug 1937  
Arterio-sclerosis 8221 1930  
Other contributory causes of importance:  
Name of operation ..... Date of .....  
What test confirmed diagnosis? Clinical 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) J S J Jones M. D.  
(Address) Macon, 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.



FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

31168

Do not use this space.

1. PLACE OF DEATH

(a) County Macon Registration District No. 533  
(b) Township \_\_\_\_\_ Primary Registration District No. 3027 Registered No. \_\_\_\_\_  
(c) City Macon (d) Street No. \_\_\_\_\_ (If death occurred in Hospital or Institution, write its name instead of street and number) St. \_\_\_\_\_  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. John J. Williamson St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) M

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 12, 1937

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

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_

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

I last saw h..... alive on \_\_\_\_\_, 19..... Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
63 10 10<sup>+</sup>

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

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
9. Industry or business in which work was done, as saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

Date of onset

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

Other contributory causes of importance:

FATHER 13. NAME

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

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

MOTHER 15. MAIDEN NAME

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

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.

17. INFORMANT (ADDRESS)

Manner of injury.....

Nature of injury.....

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify.....

(Signed) J. J. Turner, M. D.

(Address) Macon Mo

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 9/11 1937 Leo H. Kunkow Local Registrar

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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