

REC'D SEP 15 1939

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

Do not use this space.

1. PLACE OF DEATH

County Shannon Registration District No. 1077 File No. 30362
Township Spring Valley Primary Registration District No. 6088 Registered No. _____
City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

452 James Evans 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 M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed (write the word)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar. 20, 1857

| 7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, hrs. or min. |
|--------|-----------|----------|-----------|----------------------------------|
| | <u>82</u> | <u>4</u> | <u>14</u> | |

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Farmer
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) Summersville - Missouri
(STATE OR COUNTRY)

13. NAME Joel Williams - 1

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

15. MAIDEN NAME Delilah Pearson

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

17. INFORMANT Mrs Nellie Young - daughter
(ADDRESS) Summersville - Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Riley Cemetery DATE Aug. 15, 1939

19. UNDERTAKER Henry Ross - neighbor
(ADDRESS) Summersville - Mo

20. FILED 8-14-1939 Frank Hyde M.D.
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 14, 1939

22. I HEREBY CERTIFY, That I attended deceased from 1936, 19____, to 1939, 19____, 19____

I last saw him alive on Aug 12, 1939. Death is said to have occurred on the date stated above, at 2:00 A.M.

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

Heart Blocking
Stop of arm

Other contributory causes of importance:

High Blood Pressure
and Prostatic Inflammation

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) J.P. M. Daniels M. D.
Res. (Address) Summersville Mo

Every item of information should be carefully supplied. It 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.

1876 a

RECEIVED

District Health Officer No. 5,

District File Number 939 203

Date Filed 9/11/39

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

30362

Do not use this space.

1. PLACE OF DEATH
 (a) County Shannon Registration District No. 1077
 (b) Township Spring Valley Primary Registration District No. 6088 Registered No. _____
 (c) City _____ (d) Street No. _____ St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (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 James Evans Williams
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED wid

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

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

| 7. AGE | YEARS | MONTHS | DAYS | IF LESS than 1 day, hrs. or min. |
|--------|-----------|----------|-----------|----------------------------------|
| | <u>82</u> | <u>4</u> | <u>14</u> | |

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 _____

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

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

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

17. INFORMANT (ADDRESS) _____
 18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____ 19 _____
 19. FUNERAL DIRECTOR (ADDRESS) _____
 20. FILED _____ 19 _____

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-14-1939

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

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

The principal cause of death and related causes of importance were as follows:
Fall breaking hip and arm Date of onset 12:00

Other contributory causes of importance
Highb. Blood Pressure and prostatic inflammation

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? Accident Date of injury 8-10-1939
 Where did injury occur? Home (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury Fall
 Nature of injury Fracture of Hip & Arm

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify J. P. McDaniel, M. D.
James Williams
 (Signed) _____ (Address) _____

SUPPLEMENTARY

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

Local Registrar

S-30362