

UGI 10 1839

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

33161  
Do not use this space.

1. PLACE OF DEATH *Portageville*

(a) County *Portageville* Registration District No. *114*

(b) Township *Portageville* Primary Registration District No. *58517*

(c) City *Portageville* (d) Street No. \_\_\_\_\_ 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 *Chalard Williams*

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female*

4. COLOR OR RACE *Colored*

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Widowed*

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *about 1863*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min. *about 76*

8. Trade, profession, or particular kind of work done, as a sawyer, bookkeeper, etc. *Housewife*

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) *Virginia*

13. NAME *Sam Williams*

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

15. MAIDEN NAME *Wink*

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

17. INFORMANT (ADDRESS) *James Roy*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Swift, Mo* DATE *Sept 14 1899*

19. FUNERAL DIRECTOR (NAME) (ADDRESS) *Leobard Reed Co*

20. FILED \_\_\_\_\_ 19 \_\_\_\_\_

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Sept., 13, 39*

22. I HEREBY CERTIFY That I attended deceased from *Only Sept., 13, 39* after death

I last saw him alive on *Just after she died* Death is said to have occurred on the date stated above, at *6 P.* m.

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

*Apoplexy* Date of onset *Sept., 12, 39*

Other contributory causes of importance: *None*

Name of operation *None* Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? *No*

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) *A. H. Reeder*, M. D.

(Address) *Portageville, 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.

Dist. No. 21

RECEIVED

District Health Officer No. 2

District File Number 1039-240

Date Filed 10-4

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

33161

Do not use this space.

1. PLACE OF DEATH  
 (a) County Deming Registration District No. 114  
 (b) Township Butler Primary Registration District No. 3867  
 (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 Chalard Williams  
 (a) Residence, No. .... St.   
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE Col 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Wid

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) apt 1863

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
apt 76

OCCUPATION  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife  
 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) Virginis

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

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

17. INFORMANT (ADDRESS) James H. Roy  
Ward

18. BURIAL, CREMATION, OR REMOVAL PLACE buried DATE 9-14 1939

19. FUNERAL DIRECTOR (ADDRESS) Richardson & Co  
new market

20. FILED 11-14 1939 Mary W. Cook  
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-13 1939

22. I HEREBY CERTIFY, That I attended deceased from only Sept 13-1939 after death to Sept 16 1939  
 I last saw him Sept 16 1939 after death is said to have occurred on the date stated above, at 6 p.m.  
 The principal cause of death and related causes of importance were as follows:  
apoplexy

Other contributory causes of importance:  
 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) A. A. Reeder, M. D.  
 (Address) Parsonsville Mo

Date of onset  
9/12/39

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

