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

35198

PLACE OF DEATH

County Pemiscot

Township Little River
or
Village ~~Wardell~~
or
City _____ (NO. _____ St.; _____ Ward)

Registration District No. 1099 File No. 20

Primary Registration District No. 5868 Registered No. 5

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Albert Gus Williams

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: white

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Married

DATE OF BIRTH: Feb (Month) 9 (Day), 1916 (Year)

AGE: 30 yrs. 9 mos. 19 ds.

If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Teamster
(b) General nature of industry, business, or establishment in which employed (or employer): _____

BIRTHPLACE (City or town, State or foreign country): Tenn.

PARENTS

NAME OF FATHER: James Albert Williams

BIRTHPLACE OF FATHER (City or town, State or foreign country): Tenn.

MAIDEN NAME OF MOTHER: Mary Brewer

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Tenn.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James Williams

(ADDRESS) Sikeston

Filed Nov 10, 1916. Gail Moore
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Sept (Month) 28 (Day), 1916 (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 27, 1916, to Sept 28, 1916, that I last saw him alive on Sept 28, 1916 and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Accident, Log struck him in back / bursting wall of bladder

_____ (Duration) _____ yrs. 17 mos. _____ ds.

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Gail Moore M. D.

Oct 21, 1916 (Address) Wardell Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL: Wardell Mo

DATE OF BURIAL: Sept 29, 1916

UNDERTAKER: F. B. Bales

ADDRESS: Pascola, Mo.

PLACE OF DEATH

County _____

Township _____ or Village _____ or City _____ (NO. _____ _____ St.; _____ Ward)

MISSOURI STATE BOARD OF H

BUREAU OF VITAL STATISTIC

CERTIFICATE OF DEATH

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

[If death' hospital o give its N of street a

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH _____ (Month) _____ (Day) _____, 1_____ (Year)

AGE _____ yrs. _____ mos. _____ ds. | If LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER (City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER (City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191____. _____
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____ (Day

I HEREBY CERTIFY, that I attended dece

_____, 191____, to _____

that I last saw h_____ alive on _____

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

_____

_____

_____

_____ (Duration) _____ yrs. _____ mos.

Contributory _____
(SECONDARY)
_____ (Duration) _____ yrs. _____ mos.

(Signed) _____

_____, 191____ (Address) _____

*State the Disease Causing Death, or, in deaths from Violent C (1) Means of Injury: and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRAN RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL	DATE OF BURI
UNDERTAKER	ADDRESS

The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria*

beginning of illness.