

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

Do not use this space.

20379

1. PLACE OF DEATH

County Greene

Registration District No. 318

File No. _____

Township _____

Primary Registration District No. 2001

Registered No. 427

City Springfield (No. 836)

S. Main

St. _____ Ward _____

2. FULL NAME

Emma Bell Williams

(a) Residence. No. 836 S. Main St. _____ Ward _____

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

Colored

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

Widow

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

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

Apr. 25 1873

7. AGE

YEARS 55 MONTHS 1 DAYS 9 If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

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

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Tex

10. NAME OF FATHER

Robert Foster

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Tex

12. MAIDEN NAME OF MOTHER

Loggie M. Cunn

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Tex

14. INFORMANT

Chessie Yoakum

(Address) 836 S. Main

15.

6-6-28 REGISTRAR O. H. Foster

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

6-4 1928

I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____,

that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Diabetes Mellitus

(duration) 0 yrs. 0 mos. 14 da.

CONTRIBUTORY (SECONDARY) Accident

(duration) _____ yrs. _____ mos. 2 da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

0 DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Specimen

(Signed) J. W. Smith, M. D.

, 19____ (Address) 401 54 Louis

*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

South Hazelwood

DATE OF BURIAL

June 19 28

20. UNDERTAKER

W. P. Campbell

ADDRESS

869 Wash.

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.

3

100

100

100

100

100

100

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.
 County Greene Registration District No. 318 File No.
 Township Primary Registration District No. 2001 Registered No. 427
 City Springfield St. Ward)

2. FULL NAME Emma Bell 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 F 4. COLOR OR RACE Col 5. SINGLE, MARRIED, WIDOWED OR DIVORCED W (write the word)
 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.

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)

(c) Name of employer

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

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 4 1928
 17. I HEREBY CERTIFY, That I attended deceased from to 19.....
 that I last saw h. alive on 19....., and that death occurred, on the date stated above, at..... m.
 THE CAUSE OF DEATH* WAS AS FOLLOWS:
 (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.....
 WHAT TEST CONFIRMED DIAGNOSIS.....
 (Signed), M. D.
 , 19 (Address)

*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.

SUPPLEMENTARY

14. INFORMANT (Address)

15. FILED 6-6 1928 October 28 REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL June 6 1928
 20. UNDERTAKER ADDRESS

REGISTRAR SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

Physicians should state EXACTLY. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. CAUSE.

S-20379