

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

Do not use this space.

1602

1. PLACE OF DEATH

County Franklin Registration District No. 411
 Township Franklin Primary Registration District No. 2,002
 City Franklin (No.) St. Ward

File No.
 Registered No. 36

2. FULL NAME

(a) Residence. No. St. Ward.
 (Usual place of abode) 1202 Penn. Ave. (President, give city or town and State)
 Length of residence in city or town where death occurred 77 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
 4. COLOR OR RACE W.
 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (with the word) widow
 5A. IF MARRIED, WIDOWED OR DIVORCED HUSBAND OF (OR) WIFE OF Ben Williams
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 11 1840
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
88 2 10
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work retired
 (b) General nature of industry, business, or establishment in which employed (or employer) Housewife
 (c) Name of employer

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

10. NAME OF FATHER Head
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Tennessee
 (STATE OR COUNTRY)
 12. MAIDEN NAME OF MOTHER no record
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) no record
 (STATE OR COUNTRY)

14. INFORMANT Jamuel J. McAllister
 (Address) Franklin Mo

15. FILED 1/23 1930 W. Benson Clark
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-21-30
 17. I HEREBY CERTIFY, That I attended deceased from Jan 14, 1930 until Jan 21, 1930 that I last saw him alive on Jan 21, 1930 and that death occurred, on the date stated above, at 12-40 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Arteriosclerosis
97
 (duration) yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) 918
 (duration) yrs. mos. ds.

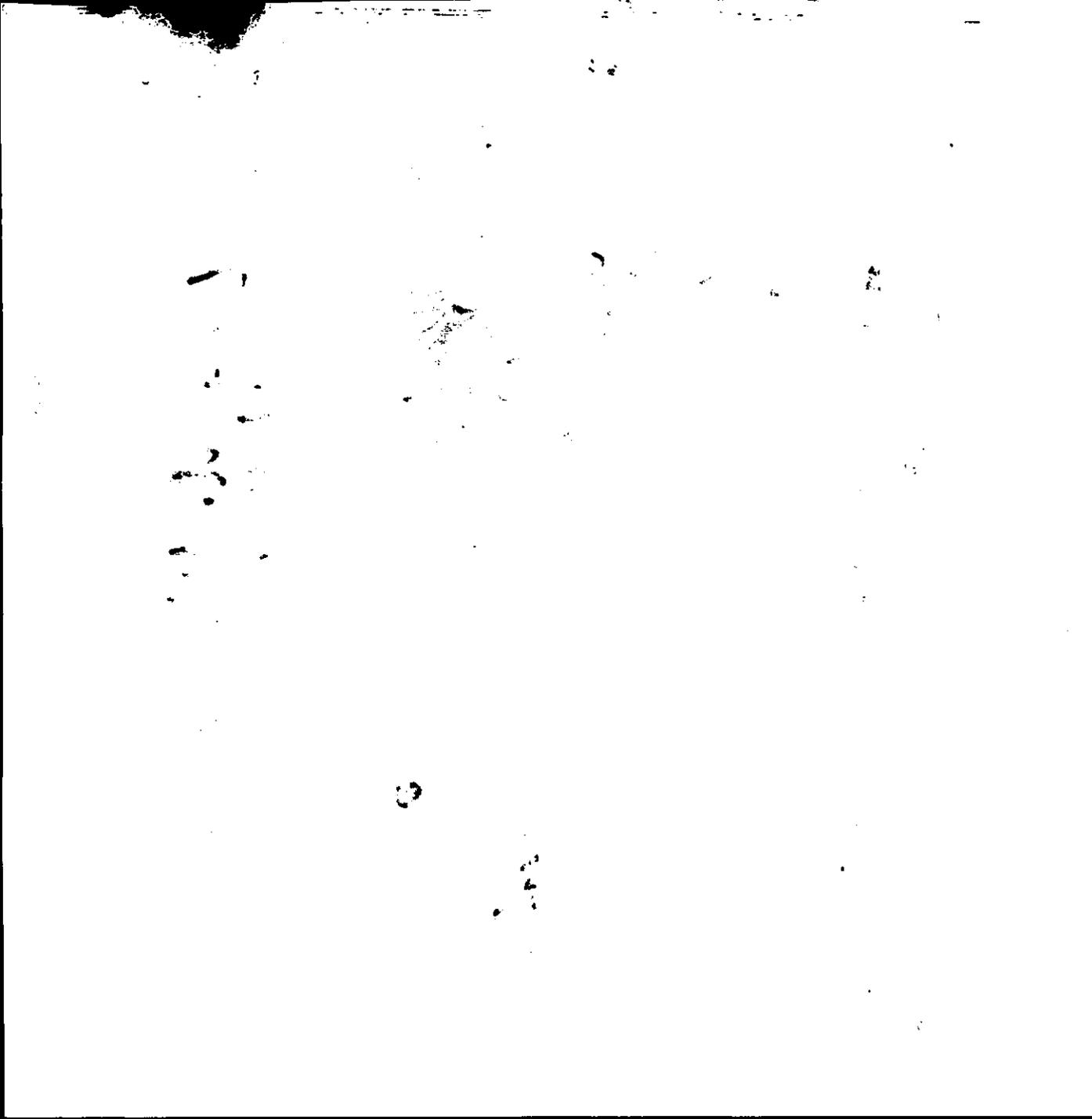
18. WHERE WAS DISEASE CONTRACTED 918
 IF NOT AT PLACE OF DEATH
 8 DID AN OPERATION PRECEDE DEATH? DATE OF
 WAS THERE AN AUTOPSY?
 WHAT TEST CONFIRMED DIAGNOSIS
 (Signed) V. E. Kennedy, M. D.
1-21-19 (Address) Franklin Mo

*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 Ass. Mo., Penn. DATE OF BURIAL 1-23-30

20. UNDERTAKER Wurld's End Co ADDRESS Franklin Mo

PARENTS



**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 Wasper Registration District No. 411 File No. _____
 Township _____ Primary Registration District No. 2002 Registered No. 26
 City Joplin (No. _____) St. _____ Ward _____

FULL NAME

Mary A. 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 W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) wid

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 11 - 1870

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
89 2 10

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) _____

14. INFORMANT _____
 (Address) _____

15. FILED 3/13 1930 A. Benson Clark
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 21 1930

17. I HEREBY CERTIFY That I attended deceased from _____
 19____ 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:

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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL _____

20. UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY

S 1602