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

Do not use this space.
25533

1. PLACE OF DEATH
County Saline Registration District No. 796
Township ~~Nelson~~ Primary Registration District No. 6039
City Nelson Mo (No. ..... St. ..... Ward)

File No. .....
Registered No. 95

2. FULL NAME Jack 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: Male
4. COLOR OR RACE: Col
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1855

7. AGE: Years 75; Months; Days; If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Labor
(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): Nelson Mo

PARENTS
10. NAME OF FATHER: Walter Williams
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Sedalia Mo
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Nelson Mo

14. INFORMANT: Henry Williams
(Address) Marshall Mo

15. FILED 8-4, 1930 Mrs. John H. McGuire
REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 27th 1930

17. I HEREBY CERTIFY, That I attended deceased from July 26th, 1930 to July 27, 1930. That I last saw him alive on July 27, 1930, and that death occurred, on the date stated above, at 4 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Cardiac Dilatation
122B
95B
173D
Sudden (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Intestinal Obstruction
(duration) yrs. mos. 3 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH Marshall Mo.
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Physical Exam.
(Signed) W. Madison, M. D.
, 19 (Address) Marshall 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: Fairview Cem
DATE OF BURIAL: July 29 1930

20. UNDERTAKER: Ferguson Williams
ADDRESS: Marshall Mo

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 Saline — Registration District No. 796 — File No. .....

Township Marshall — Primary Registration District No. 6039 — Registered No. .....

City ..... (No. ....., ... St. ..... Ward)

2. FULL NAME Jack 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
M	Col	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.

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)

PARENTS

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 8-4, 1930 Mrs. John H. McGuire
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 27 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:
Acute Cardiac dilatation
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Intestinal Obstruction
Possibly paralysis (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 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

REGISTRAR ... EE FO ... TIF ... EY A ... COMPL TE AS ... RIBED BY LAW

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