

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

Do not use this space.

1. PLACE OF DEATH

County Saline
Township Marshall
City Marshall No. _____

Registration District No. 996
Primary Registration District No. 3038

File No. 22804
Registered No. 91 St. _____ Ward _____

2. FULL NAME

Baxter Randall Williams

(a) Residence, No. _____ St. _____ Ward _____
(Usual place of abode)

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Col 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov 9, 1902

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
32 7 15

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Laborer

9. Industry or business in which work was done, as silk mill, 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) Marshall

13. NAME John Williams

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Marshall

15. MAIDEN NAME Mary Talbot

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

17. INFORMANT (ADDRESS) John Williams
Marshall, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Farmers DATE June 26, 1934

19. UNDERTAKER (ADDRESS) Ferguson Williams
Marshall, Mo.

20. FILED 6/24/34 Saline Deputy Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-24 1934

22. I HEREBY CERTIFY, That I attended deceased from June 18 1934 to June 24 1934. I last saw him alive on June 24 1934. Death is said to have occurred on the date stated above, at 6 a.m.

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

Sumo of Brain

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 _____ 1934

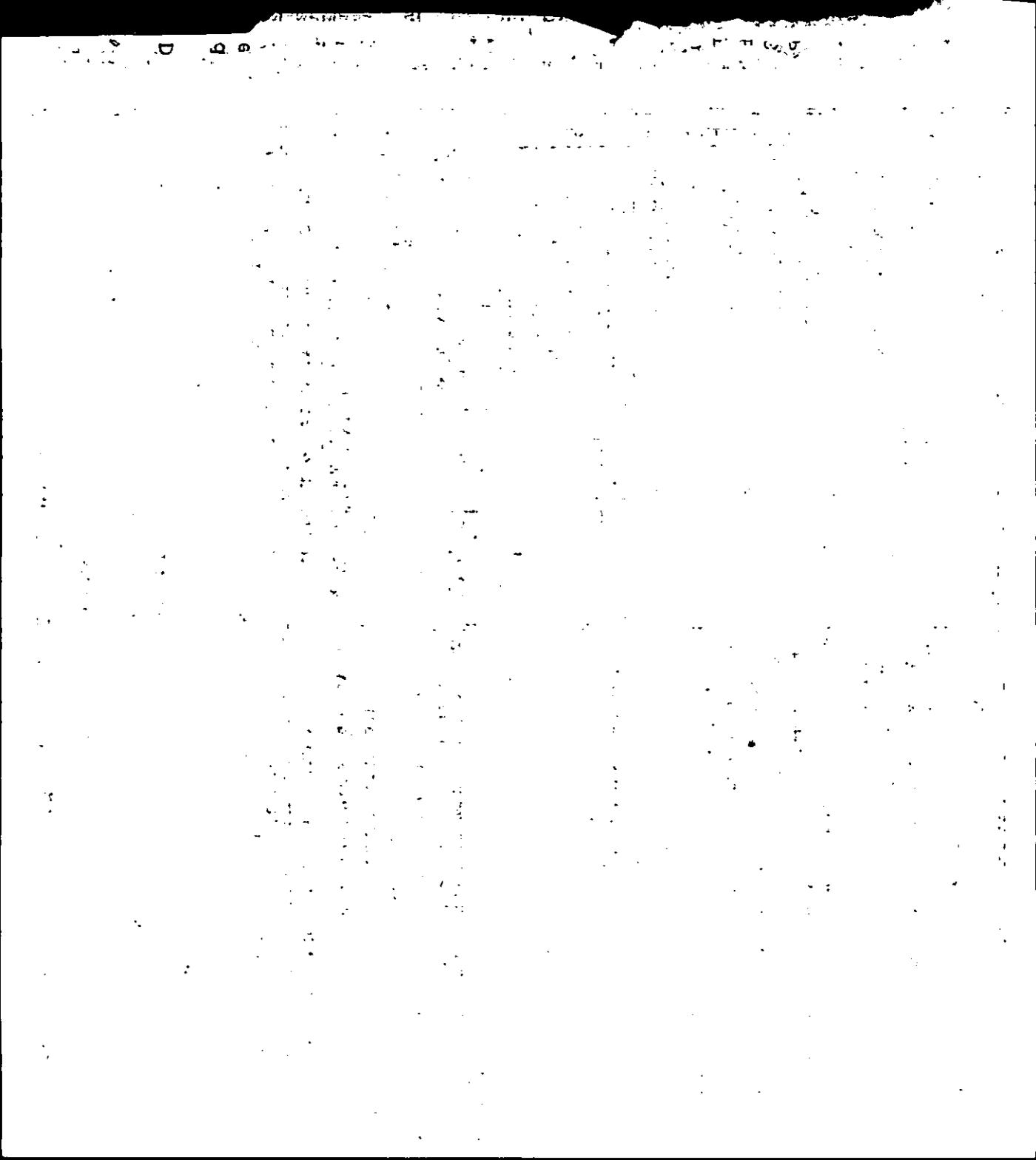
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? If so, specify _____

(Signed) W. H. Webb M. D.
(Address) Marshall, Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. **JUL 14 1934**



Saline

WASHINGTON

91

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: Roster Randall Williams

Who died at Marshall mo on June 24 - 1934

Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____

Sex m Color or race Black Single, ~~married~~, ~~widowed~~ or ~~divorced~~: _____

Date of birth _____ Age: Years 32 Months 7 Days 15

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. (b) Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Date deceased last worked at this occupation: Month _____ Year _____

Birthplace (State or country) _____

Birthplace of father (State or country) _____

Birthplace of mother (State or country) _____

Principal cause of death: Tumor of Brain

Malignancy Suspected

Other contributory causes of importance _____

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

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 _____

Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

Name of physician _____

Address of physician _____

Signature of Registrar H. Conway

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Very truly yours,

Reg. Dist. No. 796

Primary Reg. Dist. No. 3036

Special Agent.

WRITE PLAINLY WITH UNIFORMITY

S-22804