

AUG 27 1935

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

Do not use this space.

27155

1. PLACE OF DEATH
 County Way modicid Registration District No. 604
 Township Le Beau Primary Registration District No. 5-805
 City Pain Pleasant (No. _____) St. _____ Ward _____

2. FULL NAME Matth 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

MEDICAL CERTIFICATE OF DEATH

3. SEX female 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

6. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Byas Dymken

6. DATE OF BIRTH (MONTH, DAY AND YEAR) about 1886

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
about 49

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

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 _____

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 17 1935

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

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at 12:45 a.m.

The principal cause of death and related causes of importance were as follows:
Typhoid fever Date of onset _____

Other contributory causes of importance: _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Senn.

MOTHER FATHER

13. NAME Ben Williams

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

15. MAIDEN NAME unk

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

17. INFORMANT (ADDRESS) Eddy Jewell Pain Pleasant

18. BURIAL, CREMATION OR REMOVAL PLACE Pain Pleasant DATE Aug 17 1935

19. UNDERTAKER (ADDRESS) Richard Hudco, Way modicid, Mo

20. FILED _____ 19____ Registrar _____

Name of operation _____ Date of _____

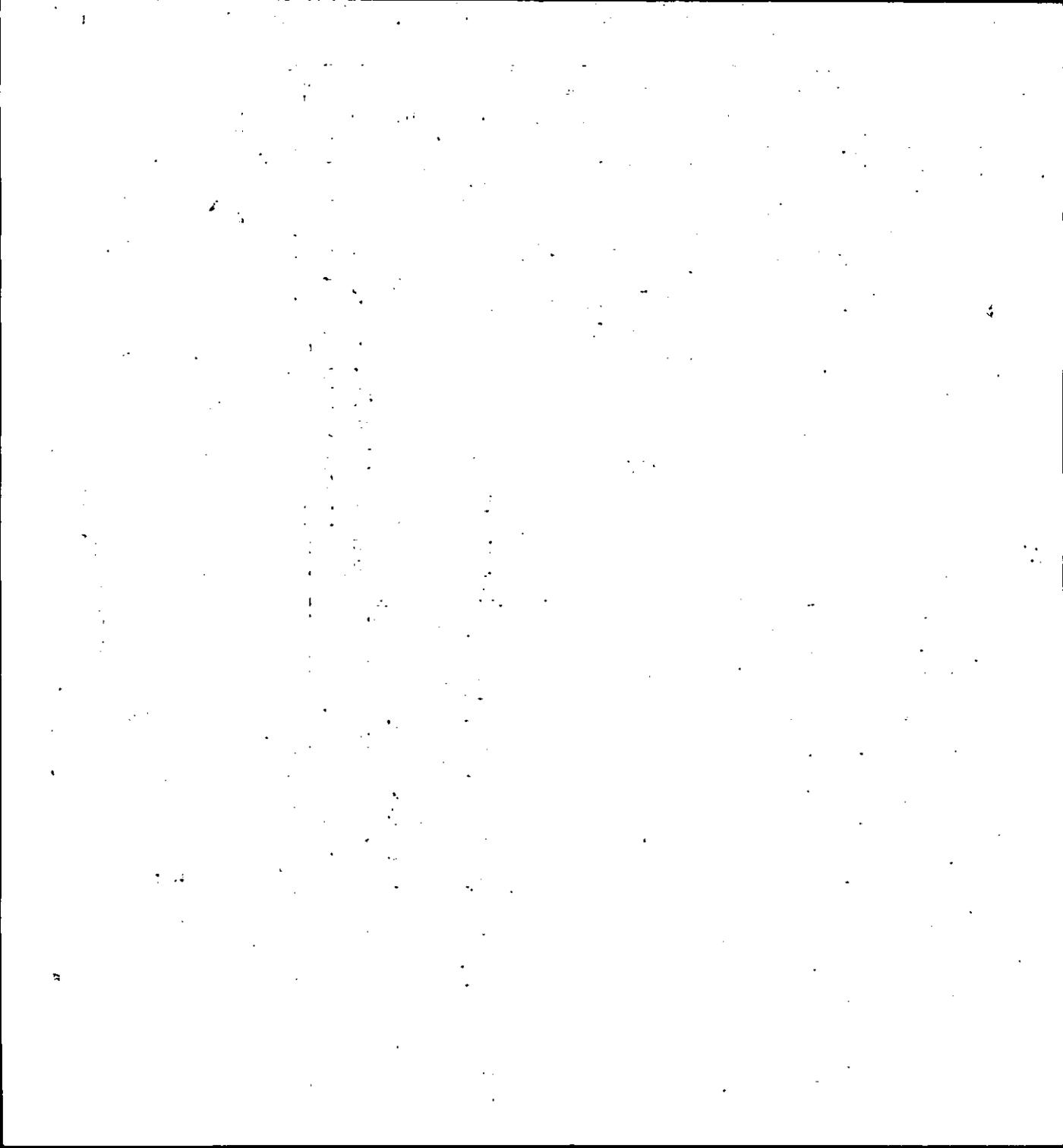
What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 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 _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify Claude M. Rowe M. D.
 (Signed) _____ (Address) Way modicid, Mo

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.



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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY PAGE.
Do not use this space.

1. PLACE OF DEATH

County New Madrid Registration District No. 604
Township..... Primary Registration District No. 5805
City..... (No., St. Ward)

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

2. FULL NAME

Mattie 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

MEDICAL CERTIFICATE OF DEATH

3. SEX 7 4. COLOR OR RACE col 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid

21. DATE OF DEATH (MONTH, DAY, AND YEAR) aug 17, 1931

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

22. I HEREBY CERTIFY, That I attended deceased from 19... to 19...
I last saw him alive on 19... Death is said to have occurred on the date stated above, at.....m.

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. abt 49

Date of case

OCCUPATION 8. Trade, profession, or particular kind of work done, as splainer, sawyer, bookkeeper, etc.
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

Encephal. Meninge
Other contributory causes of importance:
9
Name of operation..... Date of.....
What test confirmed diagnosis?..... Was there an autopsy?.....

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

13. NAME *

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19...

19. UNDERTAKER (ADDRESS)

20. FILED 9/17 1931 W. H. Cannon Registrar.

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

(Signed) Charles McRaven M. D.
Marston, Mo. (Address)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

SUPERINTENDENT

SEP 4 1953

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