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.

REC'D APR 6 1939

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

10095
Do not use this space.

1. PLACE OF DEATH
(a) County BUCHANAN — Registration District No. 85
(b) Township — Primary Registration District No. 1001 — Registered No. 250
(c) City ST. JOSEPH — (d) Street No. MO. METHIDIST HOSPITAL St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

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2. PRINT FULL NAME EDWARD D. WILLIAMS
(a) Residence, No. 206 So. 22nd St. St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Negro
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Lorain Williams
6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Jan. 1st 1892
7. AGE: YEARS 47 — MONTHS 2 — DAYS 9 — If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.: Steward
9. Industry or business in which work was done, as saw mill, bank, etc.: Benton Club
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): St. Joseph Mo. 0

FATHER
13. NAME: Owen J. Williams 9
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Unknown Unknown 0

MOTHER
15. MAIDEN NAME: Kathryn Cupp
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): St. Joseph Mo.

17. INFORMANT (ADDRESS): Lorain Williams 206 So. 22nd St.
18. BURIAL, CREMATION, OR REMOVAL PLACE: Soldiers Home Leavenworth Ks. DATE: Mar. 14/'39
19. FUNERAL DIRECTOR (NAME) (ADDRESS): RAMSEY'S MORTUARY 1602 Messanie St.
20. FILED: Mar 14, 1939 H. J. Nestlebush Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): March 10th, 1939
22. I HEREBY CERTIFY, That I attended deceased from 3-5, 1939, to 3-10, 1939
I last saw him alive on 3-10, 1939. Death is said to have occurred on the date stated above, at 2.30 p.m.
The principal cause of death and related causes of importance were as follows:

Lobar pneumonia — Date of onset 2-28-39

Other contributory causes of importance: 108

Name of operation: None — Date of
What test confirmed diagnosis? Autopsy — Was there an autopsy? Yes

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? No
If so, specify
(Signed) Paul Forgrave, M. D.
(Address) St Joseph Mo

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, ...

....., or by .....

Registered Apprentice No....., working under my personal supervision.

Signed J. F. Ramsey

Licensed Embalmer No. 4081

P. O. Address 1602 Messaris

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.