

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

6630
Do not use this space.

1. PLACE OF DEATH
 (a) County GREENE Registration District No. 318
 (b) Township 1 Primary Registration District No. 2901 Registered No. 149
 (c) City SPRINGFIELD (d) Street No. 0 (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.

2. PRINT FULL NAME LESTER TRAY WILLIAMS
 (a) Residence, No. Springfield R-8 St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 26-1922

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
21 7 9 16

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc. Farmer
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

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

FATHER
 13. NAME Robert A. Williams
 14. BIRTHPLACE (CITY OR TOWN) Gainsville (STATE OR COUNTRY) MO

MOTHER
 15. MAIDEN NAME Emma A. Nydegger
 16. BIRTHPLACE (CITY OR TOWN) Shoager (STATE OR COUNTRY) MO

17. INFORMANT Emma Williams (ADDRESS) R-8 Springfield

18. BURIAL, CREMATION, OR REMOVAL
 PLACE Republic DATE 2-14 1940

19. FUNERAL DIRECTOR (NAME) Wynn (ADDRESS) Springfield MO

20. FILED 2-14 1940 Chas. A. Gandy Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 12 1940

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____.
 I last saw him dead on Feb 12, 1940. Death is said to have occurred on the date stated above, at 3:30 p.m.
 The principal cause of death and related causes of importance were as follows:
Fractured skull
Extra cranial hemorrhage
 Date of onset

Other contributory causes of importance:
1870

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? accident Date of injury 2-12, 1940
 Where did injury occur? R. R. 8 Greene County (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. Home

Manner of injury falling trees and support hole
 Nature of injury allowing him to fall on head

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) H. M. White, M. D.
 (Address) Greene County

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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 MAR 19 1940

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.....

Lloyd W. Fox

Licensed Embalmer No. 2910

P. O. Address 629 W Walnut

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.

X