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

Do not use this space.

37917

File No. 1

Registered No. 26

1. PLACE OF DEATH

County Ray

Township

City Lawson (No. ..... St. ..... Ward)

Registration District No. 742

Primary Registration District No. 3972a

2. FULL NAME Mrs Rachel 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)
F	W	Widow

5a. IF MARRIED, WIDOWED, OR DIVORCED ~~HUSBAND OF~~ (OR) ~~WIFE OF~~ Ty Williams

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

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	74	1	13	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House keeper

(b) General nature of industry, business, or establishment in which employed (or employer) X

(c) Name of employer X

9. BIRTHPLACE (CITY OR TOWN) Emmack Mo

(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Dodson Rowland

11. BIRTHPLACE OF FATHER (CITY OR TOWN) ?

(STATE OR COUNTRY) North Carolina

12. MAIDEN NAME OF MOTHER Mary Lyman

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) X

(STATE OR COUNTRY) Vermont

14. INFORMANT J E Bond

(Address) Exceelsior Springs Mo

15. FILED Dec 5 19 28 Edwin Shouse

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 30th 1928

17. I HEREBY CERTIFY, That I attended deceased from Nov 4th, 19 28, to Nov 30th, 19 28, that I last saw h.e.r. alive on Nov 29th, 19 28, and that death occurred, on the date stated above, at 6 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Diabetes Mellitus

59

(duration) dont know yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 57

(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH .....

DID AN OPERATION PRECEDE DEATH? No DATE OF .....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) Edwin Shouse, M. D

, 19 (Address) Lawson 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 Rowland Cemetery

DATE OF BURIAL Dec 2 19 28

20. UNDERTAKER E M Ward

ADDRESS Lawson Mo

Item of information not supplied. AGE should be carefully supplied. PHYSICIANS should state DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important.

[illegible] blue [illegible] 75 [illegible]
[illegible] gom [illegible]

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 Ray Registration District No. 742 File No. 1
Township Polk Primary Registration District No. 5-977a Registered No. 20
City ..... (No. ..... St. ..... Ward)

2. FULL NAME Mrs Rachel 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)
F	W	Wid

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 10-17-1854

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	74	1	13	

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)

FILED Dec 8. 1928 Edwin Shouse
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 30 1928

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:

.....

.....

.....

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....

..... (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

N. B.—Every ... CAUSE OF ... A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-37917