

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

Do not use this space.

18624

1. PLACE OF DEATH

County Monticau
Township Linn
City _____

Registration District No. 574
Primary Registration District No. 5712A

File No. 1934
Registered No. _____
St. _____ Ward _____

2. FULL NAME

George Conrad Williamson

(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 male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 16, 1865

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
68 8 9

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmers
(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) Missouri

10. NAME OF FATHER

unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) unknown

12. MAIDEN NAME OF MOTHER

unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) unknown

14. INFORMANT

Mrs Raymond McDaniel
(Address) Prairie Home Mo

15. FILED

460-34 Ellis Drake
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2 16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-22, 1934

17. I HEREBY CERTIFY, that I attended deceased from May 11-25, 1934 that I last saw him alive on 4-24, 1934 and that death occurred, on the date stated above, at 9 P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
22A Tuberculosis
31 of lungs
(duration) 2 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Tuberculosis of Tongue
(duration) 6 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) A. K. Hurdick, M. D.
4/27, 1934 (Address) Prairie Home 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 Union Cemetery DATE OF BURIAL 4/27 1934

20. UNDERTAKER Calbert Hornbeck ADDRESS Prairie Home Mo

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.

MAY 23 1934

