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.

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

15909

1 PLACE OF DEATH

County .....

Township ..... or Village ..... or City St Louis Mo (NO. City Hospital St. 16 Ward)

Registration District No. 791 File No. .....

Primary Registration District No. 1003 Registered No. 4439

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME 575 Joe Williams

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Widower

6 DATE OF BIRTH: Jan (Month) 1 (Day), 1867 (Year)

7 AGE: 52 yrs. 3 mos. 28 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry business, or establishment in which employed (or employer): Day

9 BIRTHPLACE (City or town, State or foreign country): Mississippi

PARENTS

10 NAME OF FATHER: Nelson Mosley

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Not known

12 MAIDEN NAME OF MOTHER: Maria Sweeney

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): N. Carolina

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Otto Fritsch

(Address) City Hospital

15 Filed APR 30 1919, 191 Max C Starkloff Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: April (Month) 28 (Day), 1919 (Year)

17 I HEREBY CERTIFY, that I attended deceased from April 15, 1919, to April 28, 1919, that I last saw him alive on April 28, 1919, and that death occurred, on the date stated above, at 1 1/2 a.m.

The CAUSE OF DEATH* was as follows:

Sarcoma left breast.

50

1919 43 (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Broncho-pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Hilling M. D.

4-28, 1919 (Address) City Hospital

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. 13 ds. In the State 18 yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence: 3536 Pepin

19 PLACE OF BURIAL OR REMOVAL: Greenwood

DATE OF BURIAL: May 1st, 1919

20 UNDERTAKER: W. C. Gordon

ADDRESS: 2649 Morgan

Williams

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

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

..... 1..... (Month) (Day) (Year)

7 AGE ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

..... 191..... (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191.....
that I last saw h..... alive on ....., 191.....,
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.

(Signed) ..... M. D.

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191.....
20 UNDERTAKER	ADDRESS

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.

Williams