

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

✓ 12811

JUN 1 1927

**1. PLACE OF DEATH**  
 County St. Louis Registration District No. 788  
 Township Webster Groves Primary Registration District No. 788  
 City Webster Groves (No. 470) Greeneville St. 29 Ward

**2. FULL NAME** Montie Williams Robert Lewis  
 (a) Residence No. 440 Greerway St. 29 Ward. (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 MEDICAL CERTIFICATE OF DEATH**

**3. SEX** m **4. COLOR OR RACE** W.C. **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** married

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

**6. DATE OF BIRTH (MONTH, DAY AND YEAR)** Dec 29-1877

<b>7. AGE</b>	<b>YEARS</b>	<b>MONTHS</b>	<b>DAYS</b>	<b>IF LESS than 1 day, — hrs. or — min.</b>
<u>49</u>	<u>3</u>	<u>29</u>		

**8. OCCUPATION OF DECEASED**  
 (a) Trade, profession, or particular kind of work Printer  
 (b) General nature of industry, business, or establishment in which employed (or employer) Employer  
 (c) Name of employer

**9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)** near Jefferson City Mo

**10. NAME OF FATHER** not known

**11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)** no

**12. MAIDEN NAME OF MOTHER** Miss Dickson

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)** no

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** April 18 1927

**17. I HEREBY CERTIFY, That I attended deceased from** April 17 1927, to April 18 1927 that I last saw him alive on April 18 1927, and that death occurred, on the date stated above, at 6:15 A.M.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**  
Pneumonia due to influenza  
132 A  
1072 (duration) yrs. mos. 1 ds.

**CONTRIBUTORY (SECONDARY)** influenza (duration) yrs. 10 mos. ds.

**18. WHERE WAS DISEASE CONTRACTED**  
 IF NOT AT PLACE OF DEATH. no

**19. DID AN OPERATION PRECEDE DEATH?** no DATE OF no

**20. WAS THERE AN AUTOPSY?** no

**WHAT TEST CONFIRMED DIAGNOSIS?** Funeral home  
 (Signed) R. Williams, M. D.  
 , 19 (Address) 111 W. Belwood

\*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. (See reverse side for additional space.)

**14. INFORMANT** Mrs. Montie Williams  
 (Address) 440 Greerway (Widow)

**15. FILED** 4-27 Pitkin H. Hodder REGISTRAR  
per Elsie Newton

**19. PLACE OF BURIAL, CREMATION, OR REMOVAL** New St. Marcus  
**20. UNDERTAKER** Hodder-Holders

**DATE OF BURIAL** Apr 20 1927  
**ADDRESS** 233 1/2 Belmont

Exact Statement of OCCUPATION is very important. Occupations to be properly classified.

# Revised United States Standard Certificate of Death

(Approved by U. S. Consus and American Public Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed: As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework or At home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report

"Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name, origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasma); *Measles, Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, OR HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*), may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

MISSOURI STATE BOARD OF HEALTH  
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CERTIFICATE OF DEATH

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County St. Louis Registration District No. 788 File No. ....  
Township Wheeler Primary Registration District No. 4771 Registered No. 29  
City St. Louis St. .... Ward) .....

2. FULL NAME

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

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

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

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

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

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)

15. FILED 6-17-27 Arthur H. Keating REGISTRAR  
per Elsie Nelson

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 8 1927

17. I HEREBY CERTIFY That I attended deceased from ..... 19....., 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:

Paralysis due to hypertension (General Paralysis)  
Contributory nephritis  
(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.....

129B  
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

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

5-12811