

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

Do not use this space.

29026

**1. PLACE OF DEATH**

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City St. Louis (No. City Hospital #2)

File No. ....

Registered No. **8610**

St. ....

Ward) .....

**2. FULL NAME**

William Steel

(a) Residence. No. 1913 Papin St., 22 Ward.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 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

Negro

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)

not known

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

W

48

?

?

8. OCCUPATION OF DECEASED

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

Labourer

(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)

Ala.

10. NAME OF FATHER

Wm. Steel

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ala.

12. MAIDEN NAME OF MOTHER

Jarah Mck

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ala.

14.

INFORMANT (Address)

Anna J. Woodard  
City Hospital #2

15.

FILED

27 1927  
maile starceoff  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

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

Sept. 17, 1927

17.

I HEREBY CERTIFY, That I attended deceased from

9/25, 1927, to 9/17, 1927

that I last saw him alive on 9/17/1927, and that death occurred, on the date stated above, at 11/400 m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Tubercular meningitis of the Meninges

249 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

32 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

not known

DID AN OPERATION PRECEDE DEATH

no

WAS THERE AN AUTOPSY

no

WHAT TEST CONFIRMED DIAGNOSIS

clinical & lab

(Signed)

W. H. Howell, M. D.

, 19 (Address)

City Hosp #2

\*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

Washington D.

9/24 27

20. UNDERTAKER

ADDRESS

W. Hechter 3500 Putger

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.

PERMANENT RECORD

