

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

Do not use this space.

35426

1. PLACE OF DEATH

County.....

Registration District No. **791**

File No.

Township.....

Primary Registration District No. **1003**

Registered No. **10612**

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

St. Ward)

2. FULL NAME

Belle Williams

(a) Residence. No. 815 N. 16th St. 75 Ward.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. 0 mos. 0 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female | 4. COLOR OR RACE Col. | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 21 1880

7. AGE YEARS MONTHS DAYS | IF LESS than 1 day, hrs. or min.
47 | 7 | 3

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House 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) Mo.

10. NAME OF FATHER Ned Logans

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Mo.

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Va.

14. INFORMANT (Address) Dora F. Woodard, City Hospital #2

15. NOV 26 1927 FILED Max B. Starks REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 24, 1927

17. I HEREBY CERTIFY, That I attended deceased from 11/19, 1927 to 11/24, 1927, that I last saw him alive on 11/24, 1927, and that death occurred, on the date stated above, at 15:00 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Myocarditis
935

indefinite (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 900 B (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED not known

IF NOT AT PLACE OF DEATH. DID AN OPERATION PRECEDE DEATH. no DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Clinical
(Signed) J. P. 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 Columbia, Mo. DATE OF BURIAL Nov 26th 1927

20. UNDERTAKER A. L. Beal ADDRESS 2726 Lucas Ave

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.

