

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

Do not use this space.

2999

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... Primary Registration District No. 1003
 City St. Louis (No. City Hospital # 2)
 Registered No. 599 SL..... Ward.....

2. FULL NAME

Anna Williams
 (a) Residence. No. 3226 Lawton St., 71 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

2. SEX Female 4. COLOR OR RACE Col. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

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

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>abt 35?</u>	<u>?</u>	<u>?</u>	<u>?</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Party Girl
 (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) Ark.
 10. NAME OF FATHER Unknown

PARENTS

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 Anna F. Woodard
 (Address) City Hospital # 2

15. FILED JAN 17 1928 Max B. Starckoff
 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 11, 1928

17. I HEREBY CERTIFY, That I attended deceased from 12:31, 1927, to 1:11, 1928
 that I last saw her alive on 1/11/1928, and that death occurred, on the date stated above, at 12:50 P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral haemorrhage

7401 10:30 8:30 A
 (duration) yrs. mos. ds.

CONTRIBUTOR Hypertension
 (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED not known
 IF NOT AT PLACE OF DEATH.....

0 DID AN OPERATION PRECEDE DEATH? no DATE OF.....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical
 (Signed) Geo. 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 Washington Park DATE OF BURIAL 1-17-1928

20. UNDERTAKER W.S. Woodard ADDRESS 4202 Finney

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

