

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

Do not use this space.

11808

1. PLACE OF DEATH

County..... Registration District/No. **791**
Township..... City Registration District/No. **1003**
City **St. Louis** (No. **City Hospital #2**)..... St. Ward)

File No.
Registered No. **4526**.....
St. Ward)

2. FULL NAME

Fred Williams
(a) Residence. No. **4068 Cook**..... St. Ward.

(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred **20** 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 Col.
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) Unknown
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. **abt. 55**
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) **Mo.**
10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (CITY OR TOWN)..... (STATE OR COUNTRY) Unknown
12. MAIDEN NAME OF MOTHER **Hattie Ray**
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)..... (STATE OR COUNTRY) **Mo.**

14. INFORMANT **Mrs. F. Woodard**
(Address) **City Hospital #25**
15. FILED **APR 26 1928** **Mrs. C. Standorf** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Mar. 31, 1928**
17. I HEREBY CERTIFY That I attended deceased from **3/31, 1928**, to **3/31, 1928** that I last saw him/her alive on **3/31, 1928**, and that death occurred, on the date stated above, at **6:00 P.M.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Myocarditis
930
index 9013
CONTRIBUTORY (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) **Dr. Howell**, M. D.
, 19 (Address) **City Hosp. #2**

*State the DISEASE CAUSING DEATH, (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 **St. Louis Bur.** **4/3/28** DATE OF BURIAL
20. UNDERTAKER **W. Richter 3500 Geyer** ADDRESS

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

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.

