

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

Do not use this space.

21887

1. PLACE OF DEATH

County.....

Registration District No.....

791

Township.....

Primary Registration District No.....

1003

City.....

(No. *Lutheran Hospital*)

File No.....

Registered No.....

6008

St. *2* Ward

2. FULL NAME

Joseph L. McWilliams

(a) Residence, No. *6222 Wagner Ave*, St. *24* Ward.

(Usual place of abode)

Wheaton

(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

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Married

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

Sarah C. McWilliams

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

January 9, 1867

7. AGE

61

YEARS

4

MONTHS

25

DAYS

IF LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

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

Foreman

(b) General nature of industry, business, or establishment in which employed (or employer)

Post Office

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

Franklin Co.

(STATE OR COUNTRY)

Mo.

10. NAME OF FATHER

Hark M. Williams

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Not known

12. MAIDEN NAME OF MOTHER

Juda Mueller

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Not known

14.

INFORMANT

(Address)

*Mrs Sarah C. McWilliams
6222 Wagner Ave
Wheaton*

15.

FILED

*June 1 1928
Miss C. Stark*

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

June 3 1928

17.

I HEREBY CERTIFY, That I attended deceased from

19....., to

19.....

that I last saw him alive on..... 19....., and that

death occurred, on the date stated above, at.....

THE CAUSE OF DEATH WAS AS FOLLOWS:

*Simple
Acute Cerebral
Meningitis*

CONTRIBUTORY (SECONDARY)

cause unknown

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

19. DID AN OPERATION PRECEDE DEATH?

DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

*(Signed) J. W. Kerney
64, 1928
Address Dep. Coroner*

*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

Valhalla

June 5 1928

20. UNDERTAKER

ADDRESS

Elma Shepard

1167 Hamilton

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.

