

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

Do not use this space.

22662

**1. PLACE OF DEATH**

County..... Registration District No. 701  
 Township..... Primary Registration District No. J03  
 City St. Louis City Hospital # 2

File No.....  
 Registered No. 6914  
 St..... Ward.....

**2. FULL NAME**

William Boston Dawson  
 (a) Residence No. 3117 Adams St., 18 Ward.

(Usual place of abode) (If nonresident give city or town and State)  
 Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female 4. COLOR OR RACE Negro 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (use the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 3-10-1898

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
30 | 3 | 13 | — | — | —

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Domestic  
 (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) La.

10. NAME OF FATHER Nelson Williams

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

12. MAIDEN NAME OF MOTHER Lana Campbell

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

14. INFORMANT (Address) James W. Popad  
City Hospital #2

15. FILED 11-3-1923 New Orleans REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 23 1928

17. I HEREBY CERTIFY That I attended deceased from June 11 1928 to June 23 1928 and that I last saw him alive on June 23 1928 and that death occurred, on the date stated above, at 11:30 A.M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Tuberculosis  
32 1/2 (duration) yrs. mos. ds. 11 ds.  
 CONTRIBUTORY Tuberculosis Peritonitis  
 (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

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. B. Thomas, M.D.  
6/25/28 (Address) City Hospital #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 7/9-1928  
 20. UNDERTAKER Peoples Burial Co.  
 ADDRESS 5100

K. 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

