

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

Do not use this space.

27386

1. PLACE OF DEATH

County Jackson
Township Town
City K.C. Mo. (No. 3015 Van Buren - St. _____ Ward)

Registration District No. _____
Primary Registration District No. _____

File No. _____
Registered No. 3162

2. FULL NAME

Infant William Virgil Williams

(a) Residence No. 3015 Van Buren/2 (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

3. SEX M. 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Child

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 9, 1928

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min. 7

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) K.C. Mo. (STATE OR COUNTRY)

10. NAME OF FATHER John Williams

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

12. MAIDEN NAME OF MOTHER Jeana Williams

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

14. INFORMANT (Address) Mrs Phillips 3901 E 60th Terrace

15. FILED 8/19/28 M.M. Terrell REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from _____ 1928, to _____ 1928 that I last saw him/her alive on _____ 1928, and that death occurred, on the date stated above, at _____

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Supra Hemorrhage

CONTRIBUTORY (SECONDARY) CPA (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 Exam

(Signed) T. M. Quaid, M. D.

, 1928 (Address) 2544 Olive St.

*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 Calland Cem DATE OF BURIAL Aug 17 1928

20. UNDERTAKER Rose & Henderson ADDRESS City

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 IN INK, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Dr Van Groot:
26 Olive.