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

Do not use this space.

32007

1. PLACE OF DEATH

County ..... Registration District No. 791 1003 File No. 9267

Township ..... Primary Registration District No. ..... Registered No. .....

City St. Louis, Mo. (No. ..... Sanitarium St. ..... Ward)

2. FULL NAME Anna Williams

(a) Residence. No. 6222 Pennsylvania Av. 13 Ward. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 17 yrs. 4 mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 20, 1875

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	53	-	25	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Unknown
(STATE OR COUNTRY) Michigan

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Michigan
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) "

14. INFORMANT W. R. Summers
(Address) 5300 Arsenal

15. FILED SEP 17 1923 Max C. Starkloff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept. 15 1928

17. I HEREBY CERTIFY, That I attended deceased from Sept. 14, 1928 to Sept. 15, 1928 that I last saw her alive on Sept. 15, 1928, and that death occurred, on the date stated above, at 3:35 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Myocarditis
1 yr.
(duration) 1 yrs. 3 mos. 11 ds.

CONTRIBUTORY (SECONDARY) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) W. R. Summers, M. D.
9/15, 1928 (Address) 5300 Arsenal

*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
St. Matthews	9/18 1928

20. UNDERTAKER	ADDRESS
Southern	7315 S. Brady

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.

MARGIN RESERVED FOR BINDING

V. S. NO. 2.