

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

Do not use this space.

43499

1. PLACE OF DEATH

County.....
Township.....
City *St. Louis*

Registration District No. *791*
1003
Primary Registration District No. *City Hospital # 2*

File No.....
Registered No. *12819*
St..... Ward.....

2. FULL NAME

Williams Alexander Jarter
(a) Residence. No. *128 E. Haven St.* Ward.....
(Usual place of abode)
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 *Col.* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Widowed*

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. ormin.
<i>abt 56</i>				

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

9. BIRTHPLACE (CITY OR TOWN)..... *Ky*
(STATE OR COUNTRY)

10. NAME OF FATHER *Unknown*

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

12. MAIDEN NAME OF MOTHER *Unknown*

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

14. INFORMANT *Anna J. Woodard*
(Address) *City Hospital # 2*

15. FILED *C 28 1928* REGISTRAR *W. C. Stanley*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *12-7-1928*

17. I HEREBY CERTIFY, That I attended deceased from *12-6-1928* to *12-7-1928* that I last saw him alive on *12-7-1928*, and that death occurred, on the date stated above, at *2:47 A* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemiplegia (Right side)
due to cerebral hemorrhage
(duration) yrs. mos. ds. *1. ds.*
CONTRIBUTORY (SECONDARY)

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?
(Signed) *J. G. Cunningham* M. D.
, 19 (Address) *2945 Jamboree*

*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 *Greenwood Cem.* DATE OF BURIAL *Dec. 31 1928*

20. UNDERTAKER *Alumn Bros.* ADDRESS *2152 Jeff Ave*

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.

