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

Do not use this space.

16111

1. PLACE OF DEATH

County ..... Registration District No. 1003 791

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

City St. Louis (No. City Hospital #2 ..... St. ..... Ward)

File No. 4143

Registered No. .....

2. FULL NAME Willie Williams

(a) Residence. No. 2731 Clark St., 22 Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. 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)
Male	Col.	married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar. 15, 1881

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	48	0	19	

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) Mobile, Ala.
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Sam Williams

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

12. MAIDEN NAME OF MOTHER Unknown

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

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

15. FILED APR -8 1929, 19 Max [illegible] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-4- 1929

17. I HEREBY CERTIFY, That I attended deceased from 3-20-, 1929 to 4-4-, 1929 that I last saw him alive on 4-4-, 1929, and that death occurred, on the date stated above, at 8:10 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pul Tuberculosis
23A

(duration) yrs. 2½ mos. ds.

CONTRIBUTORY (SECONDARY) 31

(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, X-ray & Tal
(Signed) T. E. Cunningham, M. D
, 19 (Address) 2945 Fulton

*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
Father Dickson	4-9 1929
20. UNDERTAKER	**ADDRESS**
American Under Co	809 N19

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.

237
2
2
2