

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

Do not use this space.

16422

**1. PLACE OF DEATH**

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **St. Louis Mo.** (No. **6026 McPherson Ave.**)

File No. ....

Registered No. **4509**

St. .... Ward

**2. FULL NAME**

**Analyze Williams**

(a) Residence. No. **6026 McPherson** Ward. ....  
(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 **Female** | 4. COLOR OR RACE **White** | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Widowed**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Benjamin F. Williams**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Dec 19-1855**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
**74 7 28**

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work **At Home**  
(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) **Illinois**

10. NAME OF FATHER **Unknown Howard**

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

12. MAIDEN NAME OF MOTHER **McLaughlin**

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

14. INFORMANT **Charles E. Williams**  
(Address) **6026 McPherson**

15. FILED **APR 17 1929** **May C. Starnes** REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **April 16<sup>th</sup> 1929**

17. I HEREBY CERTIFY, That I attended deceased from ..... 19....., to ..... 19..... that I last saw h..... alive on..... 19..... and that death occurred, on the date stated above, at..... **6:00 P.** m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

**A suffocation due to fuel gas poisoning**  
**Whether accidental or intentional** (duration)..... yrs. mos. ds.

CONTRIBUTORY (SECONDARY) **not ascertained** (duration)..... yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH

19. DID AN OPERATION PRECEDE DEATH DATE OF WAS THERE AN AUTOPSY? **No.**

WHAT TEST CONFIRMED DIAGNOSIS (Signed) **John H. Perry** M.D. 4/17, 1929 (Address) **DC**

\*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 **Vandalia, Ill** DATE OF BURIAL **4/18 1929**

20. UNDERTAKER **C. R. Lupton** ADDRESS **4449 Olive St**

Fully supplied. AGE should be stated EXACTLY. PHYSICIANS should state that it may be properly classified. Exact statement of OCCUPATION is very important.

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may be properly class. of. 228

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County.....  
Township.....  
City..... *St Louis* (No.....)

Registration District No. *791*  
Primary Registration District No. *1003*

File No.....  
Registered No. *4509*  
St..... Ward.....

**2. FULL NAME**

(a) Residence. No. .... St., ..... Ward. ....  
(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 *F* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *W*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Dec 19-1883*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, ..... hrs. or ..... min.  
*73 3 27*

**8. OCCUPATION OF DECEASED**

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

(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)

PARENTS

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14.

INFORMANT (Address)

15.

FILED *TIN 28 1933*

REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Apr 16 1939*

17. I HEREBY CERTIFY That I attended deceased from..... to..... that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY)

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)....., M. D.

, 19 (Address)

\*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

19

20. UNDERTAKER

ADDRESS

*W. K. Kubton*

N. B.—Every item of information should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain language. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

SUPPLEMENTARY

5-16422