

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

Do not use this space.

1. PLACE OF DEATH

County.....
Township.....
City.....

Registration District No. **791**
Primary Registration District No. **10113**
(No. *City Hospital #2*)

File No. **19797**
Registered No. **5408**
St. Ward)

2. FULL NAME

(a) Residence, No. *1308 1/2 N. 8th* St., *125* Ward.
(Usual place of abode)

Length of residence in city or town where death occurred *52* 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 *Col.* | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Widowed* (write the word)

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. or min.
abt. 62

8. OCCUPATION OF DECEASED

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

10. NAME OF FATHER *Oliver Williams*

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

12. MAIDEN NAME OF MOTHER *Anna Petteridge*

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

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

15. FILED **MAY 15 1929** REGISTER *Wm E. Hankins*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **5-12-1929**

17. I HEREBY CERTIFY, That I attended deceased from *3-22-1929*, 19*29*, to *5-12-1929*, 19*29* that I last saw him alive on *5-7-1929*, and that death occurred, on the date stated above, at *7:40 A.M.*

THE CAUSE OF DEATH WAS AS FOLLOWS:
blw. Endocarditis
blw. myocarditis
CONTRIBUTORY (SECONDARY) *blw. nephritis*

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 *Clinical & lab*
(Signed) *F. C. Cunningham, M.D.*
, 19 (Address) *2945 Taylor*

*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 *Washington Park* DATE OF BURIAL *5/16 1929*
20. UNDERTAKER *C. W. Roberts and Co* ADDRESS *3035 Lucas*

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 PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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