MAR 28 1930

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

Do not use this space.

6281

File No. 25

Registered No. 25

1. PLACE OF DEATH

County: St Louis County — Registration District No. 1123

Township: RONDELL — Primary Registration District No. 0255

City: St Louis Mo. (No. 1414 St. Rose St. ..... St. ..... Ward)

2. FULL NAME: Howard Williams

(a) Residence. No. ..... Carpenthersville Mo. ..... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 1 mos. 5 ds. How long in U.S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Single

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Not Married

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Feb. 19 1905

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
25	25	11	15	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Machinist

(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

PARENTS

10. NAME OF FATHER: H. A. Williams

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

12. MAIDEN NAME OF MOTHER: Rose Leidenfeld

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

14. INFORMANT: ~~From attend's listing~~
(Address): H. A. Williams - Carruthersville Mo.

15. FILED: Feb 5 1930 L. C. Obrod
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Febr. 4 1930

17. I HEREBY CERTIFY, That I attended deceased from 1-6-29, 19..., to 2-4-30, 19..., that I last saw h. alive on 2-4-30, 19..., and that death occurred, on the date stated above, at 7:15 A.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chr. PUL. TUBERCULOSIS

Fibroid Pleurisy

2.3 A

110 B

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED: At home

IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? No. DATE OF —

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? Cavitation & Fibrosis of lungs

(Signed) C. Kehler, M. D.

, 19 (Address) 9101 So. Broadway

*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: Calvary Cemetery — DATE OF BURIAL: Feb. 5 1930

20. UNDERTAKER: J. H. Lebken — ADDRESS: 2842 Miramee St.

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.

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