

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

Do not use this space.

7078

1. PLACE OF DEATH

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

Registration District No. *791*
Primary Registration District No. *10038*

File No.
Registered No. *1946*
St. Ward)

2. FULL NAME

Michael Mc Williams
(a) Residence. No. *2209 Herbert* St. *20* Ward.

(If nonresident give city or town and State)

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Unknown 1850*

7. AGE *70* YEARS MONTHS *Unknown* DAYS *Unknown* LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Retired*
(b) General nature of industry, business, or establishment in which employed (or employer) *Electrician*
(c) Name of employer

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

10. NAME OF FATHER *Michael Mc Williams*

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

12. MAIDEN NAME OF MOTHER *Margaret Mc Busby*

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

14. INFORMANT *Sister Jeanne* (Address) *2209 Herbert*

15. FILED *Jan 21 1930* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *February 25 1930*

17. I HEREBY CERTIFY, That I attended deceased from *June 14 1930* to *Feb 23 1930* that I last saw him alive on *Feb 22 1930*, and that death occurred, on the date stated above, at *12 45 P.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis

CONTRIBUTORY (SECONDARY) *Arteriosclerosis* (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED? IF NOT AT PLACE OF BIRTH?

DID AN OPERATION PRECEDE DEATH? *No* DATE OF

WHAT TEST CONFIRMED DIAGNOSIS? *Clinical Examination*

(Signed) *Anthony A. Piekowski, M.D.*

2/24, 1930 (Address) 1525 a Cass Ave.

*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 *2/24 1930*

20. URBERTAKER *Arthur J. Donnelly* ADDRESS *2239 Wash 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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To Waltham Mass.

1525^a Cass Ave