

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

Do not use this space.

10289

1. PLACE OF DEATH

County.....

Registration District No. 791

File No.

Township.....

Primary Registration District No. 1003

Registered No. 2258

City St. Louis (No. Bethesda Hosp. St. Ward)

2. FULL NAME

Baby Williams

(a) Residence. No. 4106 Botanical St. Ward.

(If nonresident, give city or town and State)

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>FEM</u>	4. COLOR OR RACE <u>W.</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Single</u>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF ✓

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 27, 1930

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>✓</u>	<u>✓</u>		<u>5</u>	

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) St. Louis, Mo
(STATE OR COUNTRY) Mo

PARENTS

10. NAME OF FATHER Leo Carl Williams

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

12. MAIDEN NAME OF MOTHER Lena Motley

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

14. INFORMANT Leo Carl Williams
(Address) 4106 Botanical

15. FILED 19 May 11 1930 St. Louis REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 3 1930

17. I HEREBY CERTIFY, That I attended deceased from Feb. 27, 1930, to March 3, 1930 that I last saw h. or alive on March 3, 1930, and that death occurred, on the date stated above, at 10:25 P. m.

166 THE CAUSE OF DEATH* WAS AS FOLLOWS:

Intracranial hemorrhage (birth injury) (non-instrumental delivery) (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY? (No)

WHAT TEST CONFIRMED DIAGNOSIS Spinal puncture
(Signed) Edmund R. Sheridan, M. D.

, 19 (Address) 3903 Le Tourey

*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

Val Halla 3/6 1930

20. UNDERTAKER ADDRESS

Cullinan Bros 1700 Wash. Blvd

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.

