

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

Do not use this space.

14965

1. PLACE OF DEATH

County..... Registration District No. 791
Township..... Primary Registration District No. 1003
City St. Louis (No. Mississippi River East of Illinois) St. Ward

File No.....
Registered No. 4490

2. FULL NAME

Rev. B. C. Williams, Robert C.
(a) Residence, No. 1446 n Blair St., 25 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 <u>Male</u>	4. COLOR OR RACE <u>col</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF <u>Mary Williams</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>June 15-1900</u>		
7. AGE	YEARS <u>29</u>	MONTHS <u>10</u>
	DAYS <u>15</u>	If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. <u>Porter</u> (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) Miss

10. NAME OF FATHER Frank Williams

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

12. MAIDEN NAME OF MOTHER Linda Bord

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

14. INFORMANT Mary Williams
(Address) 1446 n Blair

15. FILED..... 19.....
Wm C. Stanley
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr. 30 1930

17. No physician in attendance
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..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Asphyxiation, due to
choking, April 20-1930
at Joan Morgan Dr. St. Louis Mo.
(duration) yrs..... mos..... ds.

CONTRIBUTORY (SECONDARY) Accident
183 (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) Joseph Hurley M. D.
4/30, 1930 (Address) Deputy Coroner

*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 Jefferson Barracks DATE OF BURIAL May 6 1930

20. UNDERTAKER Cement - son ADDRESS 2700 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.

