

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

Do not use this space.

~~21185~~
21185
File No. _____
Registered No. **6046**
St. _____ Ward)

1. PLACE OF DEATH

County _____ Registration District No. **791**
Township _____ Primary Registration District No. **1003**
City **St. Louis, Mo.** (No. **6419 a Vermont**)

2. FULL NAME James Eyre Williams

(a) Residence. No. 6419a Vermont St. 1 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 Male **4. COLOR OR RACE** White **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** Married.

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
Kate Williams

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 13, 1869

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day,	
				hrs.	min.
	60	9	3		

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Clerk (City Collector) 094ue
(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) Ireland

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Ireland

12. MAIDEN NAME OF MOTHER

Unknown Eyre.

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) England.

14.

INFORMANT Kate Williams
(Address) 6419 Vermont

15.

FILED May 2 1930 Max O. Parkey REGISTRAR

2

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 20 1930

17. I HEREBY CERTIFY, That I attended deceased from March 2nd 1930 to June 20 1930, and that I last saw him alive on June 20 1930, and that death occurred, on the date stated above, at 6 P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrhage

CONTRIBUTORY (SECONDARY) Cirrhosis of the Liver
(duration) 1 yrs. 1 mos. 0 ds.

18. WHERE WAS DISEASE CONTRACTED NOT AT PLACE OF DEATH
19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WHAT TEST CONFIRMED DIAGNOSIS Clinical Findings
(Signed) Frank Schwanz, M. D.
6/21 1930 (Address) 1730 Virginia av.

*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 Valhalla Cemetery **DATE OF BURIAL** June 23rd 30

20. UNDERTAKER Southern **ADDRESS** 6320 S. Grand.

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.

W. R. ...
... of ...