23512-B

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

Do not use this space.

23512-B

File No. .....

Registered No. 9180

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1001

City St. Louis Mo. (No. City Hospital #2 St. ..... Ward)

2. FULL NAME Baby Willis

(a) Residence. No. 52 A-22nd St., 22 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. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
male	col	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 7-8-30

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

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work none.
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

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

PARENTS
10. NAME OF FATHER Arthur Willis
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Arkansas
12. MAIDEN NAME OF MOTHER Sara Barnes
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Miss.

14. INFORMANT A. Gertrude Heath.
(Address) City Hospital #2

15. FILED ..... 24 ....., 19 ..... Mary C. Harlan
REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-19-30

17. I HEREBY CERTIFY, That I attended deceased from 7-8-, 1930, to 7-19-, 1930 that I last saw h. alive on 7-19-, 1930, and that death occurred, on the date stated above, at 3:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Malnutrition
34
158 (duration) ....yrs. ....mos. 12 ds.

CONTRIBUTORY (SECONDARY) Congenital lues (duration) ....yrs. ....mos. ....ds.

18. WHERE WAS DISEASE CONTRACTED —
IF NOT AT PLACE OF DEATH .....
DID AN OPERATION PRECEDE DEATH? no DATE OF —
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Clinical-Lab.
(Signed) Henry E. Hampton M. D.
7-19-, 1930 (Address) City Hospital #2

*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 POTTERS FIELD | DATE OF BURIAL 9/25 1930

20. UNDERTAKER L. R. Aston | ADDRESS 2945 Hawton

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. AGE should be stated EXACTLY. PHYSICIANS should state ... necessary supplied.