

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

Do not use this space.

**34113**

**1. PLACE OF DEATH**

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

Registration District No. 701  
Primary Registration District No. 1003  
(No. Lutheran Hospital)

File No.....  
Registered No. 9433  
St..... Ward.....

**2. FULL NAME**

Helen Williams

(a) Residence. No. .... St., 24 Ward. Belleview Mo

(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**

F.

**4. COLOR OR RACE**

W.

**5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)**

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

**6. DATE OF BIRTH (MONTH, DAY AND YEAR)** Aug. 1-1928

**7. AGE**

YEARS	MONTHS	DAYS	IF LESS than 1 day, .....hrs. or .....min.
<u>2</u>	<u>2</u>		

**8. OCCUPATION OF DECEASED**

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

**9. BIRTHPLACE (CITY OR TOWN)** Lester ville  
(STATE OR COUNTRY) Mo.

**10. NAME OF FATHER** Luther Williams

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

**12. MAIDEN NAME OF MOTHER** Opal Fitzpatrick

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

**14. INFORMANT** Dr. C. M. Fitzpatrick  
(Address) Lester ville Mo.

**15. FILED** ACT-2 19 May 21 19 30  
REGISTRAR May C. Stankoff

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** Oct 1 19 30

17. I HEREBY CERTIFY, That I attended deceased from Oct 1 19 30 to Oct 1 19 30 that I last saw her alive on Oct 1 19 30 and that death occurred, on the date stated above, at 2:50 P. m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Acute enteritis

12.0.13 / 1148 (duration) yrs. mos. 7 ds.

CONTRIBUTOR (SECONDARY) 1148 (duration) yrs. mos. ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH.....

8 DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Edwin P. Meiners, M. D.

Oct 1, 19 30 (Address) 6600 Delmar

\*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**

Lester ville Mo

**DATE OF BURIAL**

Oct 2 19 30

**20. UNDERTAKER**

7. Stoffer

**ADDRESS**

Sullivan Mo.

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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10