

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

Do not use this space.
34149

1. PLACE OF DEATH

County..... Registration District No. 797 File No.....
Township..... Primary Registration District No. 4827 D 2 Registered No. 9485
City St. Louis (No. City Hospital) St. Ward)

2. FULL NAME

(a) Residence. No. 1228 77 St., 25 Ward. (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>		4. COLOR OR RACE <u>White</u>		5. SINGLE, MARRIED, WIDOWED OR DIVORCED (with the word) <u>Widowed</u>	
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>unknown</u>					
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Aug 21 - 1867</u>					
7. AGE		YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
		<u>68</u>	<u>1</u>	<u>2</u>	
8. OCCUPATION OF DECEASED					
(a) Trade, profession, or particular kind of work <u>at Home</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) <u>Illinois</u>					
PARENTS	10. NAME OF FATHER <u>Samuel Williams</u>				
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Ky.</u>				
	12. MAIDEN NAME OF MOTHER <u>Mrs Kealing</u>				
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>St. Louis</u>				
14. INFORMANT (Address) <u>City Hospital</u>					
15. FILED <u>OCT - 4 1930</u> <u>M. Starkley</u> REGISTRAR					

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 2 1930

17. I HEREBY CERTIFY, That I attended deceased from Aug 9, 1930, to Oct 2, 1930 that I last saw her alive on Oct 2, 1930, and that death occurred, on the date stated above, at 6:20 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis

930 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 9485 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED? IF NOT AT PLACE OF DEATH

19. DID AN OPERATION PRECEDE DEATH? no DATE OF

20. WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS? clinical history
(Signed) Raymond S. Jacob M. D.
12. 30 (Address) City Hospital

*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
St. Matthews Cemetery 10-4 1930

20. UNDERTAKER ADDRESS
M. Laughlin 1831 mo ave.

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.

Sloan