

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

Do not use this space.

3632

1. PLACE OF DEATH

County..... Registration District No. 1791
Township..... Primary Registration District No. 1003
City..... (No. City of St. Louis) West Hospital St. 2 Ward

File No.
Registered No. 865

2. FULL NAME

Lillie Williams

(a) Residence. No. 3206 Chautauque 18 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 Female
4. COLOR OR RACE Col
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 2-1-1892

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
27 4 2

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer) Tobacco Factory
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Arkansas
(STATE OR COUNTRY) Miss

10. NAME OF FATHER Frank Williams

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

12. MAIDEN NAME OF MOTHER Alice Winston

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

14. INFORMANT West Winston
(Address) 427 S. Broadway

15. FILED 22 1931 May 11 Hank REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-19 1931

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 11:45 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Hydrocyanic Acid Poisoning

195 (duration) yrs. mos. ds.
CONTRIBUTORY Whether accidental or
(SECONDARY) intentional not ascertained
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED 42

1977 (duration) yrs. mos. ds.

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS
(Signed) Y. J. ... M.D.

1979 19 (Address) Deputy Coroner
*State the DISEASE CAUSING DEATH, omit 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 Washington Park DATE OF BURIAL 1-25 1931

20. UNDERTAKER American Funeral Home ADDRESS 3444 Pine

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.

