

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

Do not use this space.

8363

1. PLACE OF DEATH

County..... Registration District No. 721
Township..... Primary Registration District No. 3002
City St. Louis (No. ISOLATION HOSPITAL) St. Ward

File No.
Registered No. 2815
St. Ward

2. FULL NAME

Bertha May Williams
(a) Residence. No. 2649 Bernard 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 6 yrs. 0 mos. 1 da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>female</u>	4. COLOR OR RACE <u>Colored</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Feb. 25, 1925</u>		
7. AGE	YEARS	MONTHS
	<u>6</u>	<u>0</u>
		DAYS
		<u>1</u>
8. OCCUPATION OF DECEASED		
(a) Trade, profession, or particular kind of work <u>School</u>		
(b) General nature of industry, business, or establishment in which employed (or employer)		
(c) Name of employer		
9. BIRTHPLACE (CITY OR TOWN) <u>St. Louis</u> (STATE OR COUNTRY)		
PARENTS	10. NAME OF FATHER <u>Marcus Williams</u>	
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) <u>Miss ?</u> (STATE OR COUNTRY)	
	12. MAIDEN NAME OF MOTHER <u>Mrs. Hughes</u>	
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) <u>Miss</u> (STATE OR COUNTRY)		

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-26 1931

17. I HEREBY CERTIFY, That I attended deceased from 2-24 1931 to 2-26 1931 that I last saw h. alive on 2-26 1931 and that death occurred, on the date stated above, at 2:45 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Diphtheria, faucial
(duration) yrs. mos. ds. 6
10
10
CONTRIBUTORY Diphtheritic myocarditis
(SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED 10

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? no DATE OF.....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Alusaf's Rab.
(Signed) L. F. Kinsare M. D.
, 19 (Address) ISOLATION 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.

14. INFORMANT Lorraine Krower
(Address) ISOLATION HOSPITAL

15. FILED 2 19 31
REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Greenwood Blvd DATE OF BURIAL 3-4 1931

BY UNDERTAKER Hatten and Son 2769 Chouteau ADDRESS an

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

