

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

16332

Do not use this space.

1. PLACE OF DEATH

County.....
Township.....
City.....

Registration District No. **791**
Primary Registration District No. **10003**
(No. *Canaan Hospital*)

File No.....
Registered No. **4826**
St..... Ward)

2. FULL NAME

William James Alexander

(a) Residence. No. *4309 a cottage* St. *11* Ward.

Length of residence in city or town where death occurred *5* yrs. *7* mos. *24* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>Male</i>	4. COLOR OR RACE <i>Colord.</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <i>Child</i>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

Child

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Aug 23 - 1925*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day,hrs. ormin.
<i>5</i>		<i>7</i>	<i>24</i>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... *Child*
(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 *William J. Alexander*
11. BIRTHPLACE OF FATHER (CITY OR TOWN) *St. Louis*
(STATE OR COUNTRY) *Mo.*
12. MAIDEN NAME OF MOTHER *Julia Smith*
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Merriewood*
(STATE OR COUNTRY) *Mo.*

14. INFORMANT *Julia Alexander*
(Address) *4309 a cottage ave*

15. FILED *22 1931* REGISTRAR *Max C. [Signature]*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *April 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....., *6:00* a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

*Shock & Injuries
(Fractured Skull, Ruptured heart, Traumatism) Received when struck over by automobile after crossing street on side walk. Pedestrian*

18. WHERE WAS DISEASE CONTRACTED *Homicide*

IF NOT A PLACE OF DEATH.....
DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY? *Yes*

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) *[Signature]* M.D.

4/20, 1931 (Address) *Deputy [Signature]*

*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 *Washington Park* DATE OF BURIAL *April 23 1931*

20. UNDERTAKER *C. Young* ADDRESS *4400 Kennel*

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.

