

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

Do not use this space.

11244

**1. PLACE OF DEATH**

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

Registration District No. 791  
Primary Registration District No. 1003  
(No. St. Mary's Infirmary)

File No. ....  
Registered No. 3136 Ward

**2. FULL NAME**

Anna Jane Hillman  
(a) Residence, No. 2805 Franklin St. 21 Ward.

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Minor

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 16 1933

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
8 4

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. None  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year)  
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) City

FATHER 13. NAME Jim Hillman

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ark

MOTHER 15. MAIDEN NAME Virginia Weir

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ark

17. INFORMANT (ADDRESS) Virginia Hillman  
2805 Franklin

18. BURIAL, CREMATION, OR REMOVAL PLACE St. Louis U DATE 3-21 1934

19. UNDERTAKER (ADDRESS) Walter Richter  
2500 Rutgers St

20. FILED J. Bedeck Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 20 1934

22. I HEREBY CERTIFY, That I attended deceased from March 6, 1934, to March 20, 1934  
I last saw him alive on March 20, 1934 Death is said to have occurred on the date stated above, at 9:20 p.m.

The principal cause of death and related causes of importance were as follows:

23 Bronchio Pneumonia Date of onset

10779  
10779

Other contributory causes of importance:

Name of operation ..... Date of .....

What test confirmed diagnosis? ..... Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? ..... Date of injury ..... 19 .....

Where did injury occur? ..... (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....

(Signed) R. W. White, M. D.

(Address) St. Mary's Infirmary

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.

WITH UNFADING INK—THIS IS A PERMANENT RECORD

APR 25 1934



*St Louis City*

WASHINGTON 3136

11244

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: Annie Joyce Williams  
Who died at St. Marys Infirmary on Mar 20 - 1934  
Residence: No. \_\_\_\_\_ St. \_\_\_\_\_  
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_  
Sex F Color or race B Single, married, widowed or divorced: m

Date of birth July 16 - 1933 Age: Years \_\_\_\_\_ Months 8 Days 4

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.  
(b) Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Date deceased last worked at this occupation: Month \_\_\_\_\_ Year 33

Birthplace (State or country) \_\_\_\_\_

Birthplace of father (State or country) \_\_\_\_\_

Birthplace of mother (State or country) \_\_\_\_\_

Principal cause of death: Broncho pneumonia - Septic

Other contributory causes of importance Radiographic Childhood Tbc. (Lungs)

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19 \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(Specify city or town, county and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_

Name of physician P. W. White

Address of physician St. Marys Infirmary

Signature of Registrar J. F. Brebeck Date filed Oct 8 - 34

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Very truly yours,

*E. T. McLaugh*

Special Agent.

Reg. Dist. No. 791

Primary Reg. Dist. No. 100-3

S-11244