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.

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

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

1 PLACE OF DEATH

County .....

Township ..... Registration District No. 781 File No. 28295

or

Village ..... Primary Registration District No. 1003 Registered No. 8175

or

City St Louis (No. 3007 Morgan St. 19 Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Shade Williams

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Unknown (Month) 1878 (Day) (Year)

7 AGE: 42 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Daylabor
(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (City or town, State or foreign country): Ala.

PARENTS

10 NAME OF FATHER: Hard Williams

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Ala.

12 MAIDEN NAME OF MOTHER: Elise Corhan

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Ala.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ella Williams
(Address) 2134 Chestnut

15 Filed AUG 28 1918 19 Max B Starkoff Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Aug. (Month) 25 (Day), 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Aug. 6, 1918, to Aug 25, 1918, that I last saw him alive on Aug. 25, 1918, and that death occurred, on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

1 Acute gastritis

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary): chronic Gastro-duodenitis

(Duration) 1 yrs. ..... mos. ..... ds.

(Signed) H. H. G. Clark M. D.

8-26, 1918 (Address) 2302 Market

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: Greenwood

DATE OF BURIAL: Aug 30, 1918

20 UNDERTAKER: A. L. Beal

ADDRESS: 2726 Lucas

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

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ..... St. ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH
..... (Month) ..... (Day) ..... (Year)

7 AGE
.....yrs. .....mos. .....ds.

If LESS than 1 day, ...hrs. or .....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
....., 191.....
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191.....
that I last saw h.....alive on ....., 191.....
and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY .....
(Secondary)
..... (Duration) .....yrs. .....mos. .....ds.

(Signed) .....M. D.

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL
....., 191.....

20 UNDERTAKER

ADDRESS

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.

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