

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

Do not use this space.

6841

**1. PLACE OF DEATH**

County..... Registration District No. **791**  
Township..... Primary Registration District No. **1003**  
City **St. Louis, Mo.** (No. **City of W.C.**)

File No. ....  
Registered No. **2085** St. .... Ward)

**2. FULL NAME**

**Sylvester Williams**  
(a) Residence, No. **1117 N. Jefferson** Ward.

(Usual place of abode) Length of residence in city or town where death occurred **10** yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX **male** 4. COLOR OR RACE **negro** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **single**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **June 21, 1890**

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
**36 8 4**

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work **Laborer**  
(b) General nature of industry, business, or establishment in which employed (or employer) **---**  
(c) Name of employer **---**

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY) **Miss.**

**10. NAME OF FATHER**

**Will Williams**

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY) **Miss.**

**12. MAIDEN NAME OF MOTHER**

**Elen Cannon**

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY) **Miss.**

**14.**

INFORMANT (Address) **Anna Woodard City Hospital #2**

**15.**

FILED 19 **May 6** **St. Louis** REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Feb. 4 5 19 27**

17. I HEREBY CERTIFY That I attended deceased from **Jan 9** 19 **27**, to **Feb 2 5** 19 **27**, that I last saw **him** alive on **Feb 8 3 5 P.** 19 **27**, and that death occurred, on the date stated above, at **8 15 P.** m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

**Pulmonary tuberculosis**

**CONTRIBUTORY (SECONDARY)**

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? **No**, DATE OF

WAS THERE AN AUTOPSY? **No**

WHAT TEST CONFIRMED DIAGNOSIS? **Culture & laboratory**

(Signed) **J. W. Gray**, M. D. City Hosp. W.C.

\*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 Cemetery**

**DATE OF BURIAL**

**Mar 3 1927**

**20. UNDERTAKER**

**J. C. Thomas**

**ADDRESS**

**3111 Locust**

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.

