

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

Do not use this space.

35415

1. PLACE OF DEATH

County.....
Towship.....
City..... *St. Louis* (No. *City Hospital #2*)

Registration District No. **7.91**
Primary Registration District No. **1003**

File No. *10601*
Registered No. **10601** (St. _____ Ward)

2. FULL NAME

James D. Williams
(a) Residence. No. *1231 N. 8th* St., *75* Ward.

(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. *10* mos. _____ da. How long in U.S., if of foreign birth? yrs. _____ mos. _____ da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>Male</i>	4. COLOR OR RACE <i>Col.</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <i>Single</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND or (or) WIFE of		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <i>Sept. 3, 1924</i>		
7. AGE YEARS <i>1</i>	MONTHS <i>2</i>	DAYS <i>22</i>
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <i>Nil</i> (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer		

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *NOV. 25, 1927*

17. I HEREBY CERTIFY That I attended deceased from *11/21, 1927*, to *11/25, 1927*, that I last saw him alive on *11/25, 1927*, and that death occurred, on the date stated above, at *11/25, 4:10 a.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Broncho Pneumonia
1074
short (duration) yrs. _____ mos. _____ da.

CONTRIBUTORY (SECONDARY) (duration) yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH... *not known*

DID AN OPERATION PRECEDE DEATH? *no* DATE OF _____

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS? *Clinical*
(Signed) *Red Howell*, M. D.
City, *City Hospital #2*

*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 *greenwood* DATE OF BURIAL *no 26* 19 *27*

20. UNDERTAKER *a. L. Beal* ADDRESS *2726 Lucerne*

9. BIRTHPLACE (CITY OR TOWN) *Hickman Ky.*
(STATE OR COUNTRY)

10. NAME OF FATHER *Robt. Williams*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Lg*
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER *Gussie Jennings*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Denn*
(STATE OR COUNTRY)

14. INFORMANT *Anna F. Woodard*
(Address) *City Hospital #2*

15. *NOV 26 1927* FILED *19* *James B. Starke* REGISTRAR

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.

DEPARTMENT RECORD

State of New York
County of Albany

County of Albany
State of New York

County of Albany
State of New York

County of Albany
State of New York

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County.....
Township.....
City..... *St. Louis* (No.....).....St.Ward.....

Registration District No. *991*
Primary Registration District No. *1003*

File No.....
Registered No. *1040A*

2. FULL NAME

(a) Residence. No.....St.....Ward.....
(Usual place of abode) (If nonresident give city or town and State)

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

James L. Williams

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 4. COLOR OR RACE *B* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *S*

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

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

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

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....
(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)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY)

14.

INFORMANT.....
(Address)

15.

FILED..... 19 *May 6* *Starckoff*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Nov 25 1927*

17. I HEREBY CERTIFY, That I attended deceased from....., 19....., to....., 19....., (that I last saw him..... alive on....., 19....., and that death occurred, on the date stated above, at.....)

THE CAUSE OF DEATH* WAS AS FOLLOWS:

*Protective pneumonia
Primary. Information given
over phone by Dr. R. S. Howell
Nov. 25, 1927 (duration)..... yrs. mos. ds.*

CONTRIBUTORY (SECONDARY).....
(duration)..... yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED.....
IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D.
, 19 (Address)

*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..... DATE OF BURIAL.....

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY RECORD

SUPPLEMENTARY RECORD

S-35915

ATLANTA, GEORGIA

1954