

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

Do not use this space.

3771

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City *St. Louis* (No. *4137^a Blaine Ave*)

File No.....
Registered No. **375**
.....St.Ward)

2. FULL NAME

Maria Williams
(a) Residence. No. *4137^a Blaine Ave* St. *18* 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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>Female</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED <i>Widowed</i>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <i>Thomas</i>				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <i>Oct. 7, 1859</i>				
7. AGE	YEARS <i>69</i>	MONTHS <i>2</i>	DAYS <i>20</i>	IF LESS than 1 day,hrs. ormin.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work..... <i>At Home</i> (b) General nature of industry, business, or establishment in which employed (or employer)..... (c) Name of employer.....				
9. BIRTHPLACE (CITY OR TOWN)..... <i>Hillsboro</i> (STATE OR COUNTRY) <i>Missouri</i>				
PARENTS	10. NAME OF FATHER <i>Unknown</i>			
	11. BIRTHPLACE OF FATHER (CITY OR TOWN)..... <i>Hillsboro</i> (STATE OR COUNTRY) <i>Missouri</i>			
	12. MAIDEN NAME OF MOTHER <i>Unknown</i>			
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN)..... <i>Hillsboro</i> (STATE OR COUNTRY) <i>Missouri</i>			
14. INFORMANT..... <i>Frank Williams</i> (Address) <i>4137^a Blaine Ave</i>				
15. FILED..... <i>8 1929</i> <i>Max C. Stanley</i> REGISTRAR				

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Jan 7th 1929*

17. I HEREBY CERTIFY, That I attended deceased from 19....., 19....., to 19....., 19....., and that I last saw him alive on 19....., 19....., and that death occurred, on the date stated above, at *3:45 a.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Myocarditis
93c

(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) *N.M.A.*
(duration) yrs. mos. ds.

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

8 DID AN OPERATION PRECEDE DEATH..... DATE OF.....
WAS THERE AN AUTOPSY? *No.*

WHAT TEST CONFIRMED DIAGNOSIS
(Signed) *John H. Murray*
1/8 1929 (Address) *Deputy Coroner*

*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 <i>Mount Hope</i>	DATE OF BURIAL <i>1/9 1929</i>
20. UNDERTAKER <i>W. Hoffmann & Co. U.S. & Co.</i>	ADDRESS <i>781 1/2 So. Bay</i>

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD.

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.

24
22