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

Do not use this space.

File No. 19501

Registered No. 5095

1. PLACE OF DEATH

County .....

Registration District No. 791

Township .....

Primary Registration District No. 1003

City St Louis No. City Hospital #2 St. ..... Ward)

2. FULL NAME Joe Williams

(a) Residence. No. 3023 Washington Ave 21 Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 6 mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
male	Negro.	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 11-15-1924

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	4	3	19	

8. OCCUPATION OF DECEASED

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

(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) Ark.

PARENTS

10. NAME OF FATHER John Williams

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Not known

12. MAIDEN NAME OF MOTHER Mary Diggs

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

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

15. DATE OF DEATH
FILED ..... 19..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 4 1929

17. I HEREBY CERTIFY, That I attended deceased from April 28, 1929, to May 4, 1929 that I last saw him alive on May 4, 1929, and that death occurred, on the date stated above, at 9:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bronchopneumonia (Primary)

..... (duration) ..... yrs. ..... mos. 5 ds.

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

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? Clinical

(Signed) J. F. Thomas M. D.

5/6/, 1929 (Address) 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 Washington Park

DATE OF BURIAL 6-9-1929

20. UNDERTAKER Peoples Inc.

ADDRESS 3100 Franklin

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.