

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

Do not use this space.

35626

1. PLACE OF DEATH

County St. Louis Registration District No. 791
Township _____ Primary Registration District No. 1003
City St. Louis (No. Barnes Hospital) St. _____ Ward _____

File No. _____
Registered No. 10102
St. _____ Ward _____

2. FULL NAME

Infant Williams
(a) Residence. No. 4050 Cote Brillante Apt 7, _____ Ward. _____
(Usual place of abode)

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 Male 4. COLOR OR RACE Col 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Infant

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 20 - 1929

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
0 0 1

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) St. Louis
(STATE OR COUNTRY) Mo.

10. NAME OF FATHER Willie Williams

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

12. MAIDEN NAME OF MOTHER Lottie Baskin

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

14. INFORMANT Willie Williams
(Address) 4050 Cote Brillante Apt 7

15. FILED OCT 23 1929 New E. Tomlin REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-21 1929

17. I HEREBY CERTIFY, That I attended deceased from 10-20, 1929, to 10-21, 1929 that I last saw h.l.m. alive on 10-21, 1929, and that death occurred, on the date stated above, at 5:57A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

159 Crematurity
(duration) yrs. mos. ds. 16/0
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 _____
(Signed) St. Louis! M. D.
, 19 _____ (Address) St. Louis Hosp.

*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 10-23-1929
20. UNDERTAKER Galveston Funeral Home ADDRESS 4107 Finney Ave

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.

