

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

Do not use this space.

12583

**1. PLACE OF DEATH**

County DeKalb Registration District No. 399  
Township 6 East Primary Registration District No. 1002  
City 156 St (No. General Hospital) St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
Registered No. 1511

**2. FULL NAME**

Thomas Jay Williams  
(a) Residence No. 1900 1/2 East 14th 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. \_\_\_\_\_

**PERSONAL AND STATISTICAL PARTICULARS**

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF April 10 - 1926

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr 10, 1926

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
8 - 17 25

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) \_\_\_\_\_ (STATE OR COUNTRY) Missouri

10. NAME OF FATHER Tyson Williams

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

12. MAIDEN NAME OF MOTHER Evelyn Williams

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

14. INFORMANT Tyson B Williams (Address) 1900 1/2 E 14th

15. FILED 4/6 1930 Sm. M. Brown REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

15. DATE OF DEATH (MONTH, DAY AND YEAR) 4/5/1930

17. I HEREBY CERTIFY, That I attended deceased from 4/4/1930 to 4/5/1930 that I last saw him alive on 4/5/1930 and that death occurred, on the date stated above, at 6:30 p.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Epidemic Cerebro Spinal - Fever

18 (duration) yrs. mos. ds. 130

CONTRIBUTORY (SECONDARY) Nephritis, Acute

(duration) yrs. mos. ds. \_\_\_\_\_

18. WHETHER WAS DEATH ATTRACTED IF AT PLACE OF DEATH Yes

0 DID AN OPERATION PRECEDE DEATH? Yes DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? Lab + Clinical Tests  
(Signed) Wm. Smith, M. D.

4/5, 1930 (Address) Gen. Hosp #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 Blue Ridge Lany DATE OF BURIAL 4 7 1930

20. UNDERTAKER W B Moore ADDRESS 1820 E 18th

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.

