

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.

PLACE OF DEATH

County Schuyler
 Township Salt River
 or
 Village _____
 or
 City _____ (NO. _____ St. _____ Ward _____)

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

Registration District No. 807 File No. 4765
 Primary Registration District No. 6041 Registered No. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME Anna Burkhardt

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED <u>Married</u> WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH <u>Dec</u> <u>17</u> , 18 <u>36</u> (Month) (Day) (Year)		
AGE <u>79</u> yrs. <u>11</u> mos. <u>25</u> ds.		If LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION
 (a) Trade, profession, or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE
 (City or town, State or foreign country) Germany

PARENTS	NAME OF FATHER <u>Wm. Ladwig</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Germany</u>
	MAIDEN NAME OF MOTHER <u>Not known</u>
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Germany</u>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Burkhardt
 (ADDRESS) Salt River

Filed 1-1, 1917 L. B. Lanning
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec 13, 1915
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 1, 1915, to Dec 13, 1915,
 that I last saw her alive on Dec 13, 1915,
 and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

mitral regurgitation of
heart causing hypertrophy
of heart
19-5A (Duration) 19 yrs. 11 mos. 25 ds.
7513
 Contributory _____
 (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) L. B. Lanning M. D.
Dec 13, 1915 (Address) Grundy St.

* State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted
 if not at place of death? _____

Former or
 usual residence _____

PLACE OF BURIAL OR REMOVAL

Falls Cemetery

UNDERTAKER

L. O. Yaring

DATE OF BURIAL

Dec. 14, 1915

ADDRESS

Grundy St.

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

PLACE OF DEATH

County _____
Township _____
or Village _____
or City _____
(NO. _____)
Registration District No. _____
Primary Registration District No. _____
File No. _____
Registered No. _____
St. _____ Ward _____
[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (If file the word)
DATE OF BIRTH _____ (Month) _____, 191____ (Year)		
AGE _____ yrs. _____ mos. _____ ds. IF LESS than 1 day, _____ hrs. or _____ min.?		

OCCUPATION _____
(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE _____
(City or town, State or foreign country)

NAME OF FATHER _____

BIRTHPLACE OF FATHER _____
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER _____

BIRTHPLACE OF MOTHER _____
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) _____

(ADDRESS) _____

Filed _____, 191____ REGISTRAR _____

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____, 191____ (Day) _____ (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h _____ alive on _____, 191____, and that death occurred, on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows:

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (SECONDARY) _____ yrs. _____ mos. _____ ds.

(Signed) _____ (Address) _____ M. D.

* State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____, 191____

UNDERTAKER _____ ADDRESS _____