LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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.

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

1 PLACE OF DEATH

County .....

Township ..... Registration District No. 701 File No. 35833

or

Village ..... Primary Registration District No. 1003 Registered No. 9162

or

City St Louis (NO. 4056 Taft av St.; 13 Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Annie Canda

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE white

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) widowed

6 DATE OF BIRTH Feb (Month) 16 (Day), 1863 (Year)

7 AGE 55 yrs. 7 mos. 26 ds. If LESS than 1 day.....hrs. or.....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work House-work
(b) General nature of industry business, or establishment in which employed (or employer) at Home

9 BIRTHPLACE (City or town, State or foreign country) St Louis Mo

PARENTS

10 NAME OF FATHER Frank Zirny

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

12 MAIDEN NAME OF MOTHER Theresa Frolo

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Fannie Zirny

(Address) 4056 Taft av

15 Filed OCT 4 1918, 191 Max C Starkloff Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH October (Month) 2 (Day), 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from July 1, 1918, to Oct 2, 1918, that I last saw h.....alive on Oct 2, 191..., and that death occurred, on the date stated above, at 9 45 a m.

The CAUSE OF DEATH* was as follows:

Arcinoma Breast

50

131 (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic Int Nephritis

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

(Signed) Robert L Pebet M. D.

Oct 3, 1918 (Address) 1837 S 9 St

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

18 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.....

19 PLACE OF BURIAL OR REMOVAL New Picker

DATE OF BURIAL Oct 4, 1918

20 UNDERTAKER Wm. C. Moydell

ADDRESS 1926 Allen

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

1 PLACE OF DEATH

County .....

Township..... or Registration District No..... File No. .....

Village ..... or Primary Registration District No. ..... Registered No. .....

City..... (NO....., ...St.;.....Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

.....(Month) .....(Day) .....(Year)

7 AGE

.....yrs.....mos.....ds.

If LESS than 1 day,.....hrs. or.....min.?

8 OCCUPATION

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

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

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

PARENTS

10 NAME OF FATHER

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

12 MAIDEN NAME OF MOTHER

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address).....

15

Filed....., 191....., ...

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

.....(Month) .....(Day) .....(Year), 191.....

17 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) .....

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

(Signed).....M. D.

....., 191..... (Address).....

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

18 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.....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	.....191.....
20 UNDERTAKER	**ADDRESS**

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD