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. 781 File No. 36583

or

Village ..... Primary Registration District No. 008 Registered No. 10068

or

City St. Louis Mo. (NO. Isolation Hosp. St. 24 Ward)

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

2 FULL NAME Anna Niehouse

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

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

6 DATE OF BIRTH Aug. (Month) 21 (Day), 1869 (Year)

7 AGE 49 yrs. 2 mos. 1 ds. If LESS than 1 day, ... hrs. or ..... min.?

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

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

PARENTS

10 NAME OF FATHER Elysha Mageff

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

12 MAIDEN NAME OF MOTHER Hulda Pollaghoff

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. Patton

(Address) Isolation Hosp.

15 Filed OCT 28 1918, 191 Max C Starkoff Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct (Month) 22 (Day), 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Oct 17, 1918, to Oct 22, 1918, that I last saw her alive on Oct 22, 1918, and that death occurred, on the date stated above, at 1:40 p.m.

The CAUSE OF DEATH* was as follows:

107A Influenza 10

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

CONTRIBUTORY (Secondary) Bronchio pneumonia

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

(Signed) Wilsworth Kneal M. D.

10-22, 1918 (Address) Isolation Hospital

*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. 5 ds. In the State 6 yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? Not known

Former or usual residence 2627 Thomas

19 PLACE OF BURIAL OR REMOVAL Chesed Shel Emeth DATE OF BURIAL OCT 23 1918 191

20 UNDERTAKER H B [illegible] ADDRESS 4715 McPherson

LOCAL REGISTR LOCAL REGIST EAR LEAF OUT

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

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
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) ....., 1..... (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) ....., 191..... (Day) (Year)

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.

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