

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

23724

1. PLACE OF DEATH

County Linn

Township Dwight

City Clinton

Registration District No. 1137

Primary Registration District No. 5651

File No. 40

Registered No. _____

St. _____ Ward _____

2. FULL NAME

Bella Anson

(a) Residence. No. _____ St. _____ Ward _____

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

7

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Single

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

✓

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

Oct 9 - 1869

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

51

11

✓

8. OCCUPATION OF DECEASED

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

Unemployed her 10 years

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

[Redacted]

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Clinton Mo.

10. NAME OF FATHER

Pleasant Anson

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Mo.

12. MAIDEN NAME OF MOTHER

Martha J. Brown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Iowa

14.

INFORMANT

(Address)

Walter Anson
New Preston Mo R.F.D.

15.

FILED

9/12 1921

A. J. Rivers

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept. 11 1921

17. I HEREBY CERTIFY, That I attended deceased from Aug. 25, 1921, to Sept 7, 1921, and that I last saw him alive on Sept 7, 1921, and that death occurred, on the date stated above, at Clinton Mo.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Inanition Septicemia
1594

CONTRIBUTORY (SECONDARY) Inolent ulcer of
left leg. (duration) 12 yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, _____

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

20. WAS THERE AN AUTOPSY? _____

21. WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) Dr. H. L. Driscoll, M. D.

(Address) Clinton Mo.

*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

Anson Cemetery

20. UNDERTAKER

A. J. Rivers

DATE OF BURIAL

9/12 1921

ADDRESS

Clinton Mo

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

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County..... File No.....
 Township..... Registered No.....
 City..... (No.)..... St. Word)

2. FULL NAME

(a) Residence. No..... Sta. Ward.....
 (Usual place of abode)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

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

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. min.

8. OCCUPATION OF DECEASED

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

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

PARENTS

14.

INFORMANT.....
 (Address)

15.

FILED..... 19.....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)..... 19.....

17. I HEREBY CERTIFY, That I attended deceased from.....
 that I last saw him..... alive on....., 19....., to....., 19....., and that death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY)..... yrs. mos. da. (duration)

18. WHERE WAS DISEASE CONTRACTED..... yrs. mos. da. (duration)

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., 19..... (Address)....., M. D.

*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. (See reverse side for additional space.)

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DATE OF BURIAL

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ADDRESS

19