

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

Do not use this space.

22892

**1. PLACE OF DEATH**

County.....  
 Township..... *St. Louis Mo.*  
 City..... *2613 Palm St.* (No.....) St..... Ward.....  
 Registration District No..... **791**  
 Primary Registration District No..... **1003**  
 File No.....  
 Registered No..... **6562**

**2. FULL NAME**

*Anna Revelle*  
 (a) Residence. No. *2613 Palm* St., *20* Ward.....  
 (Usual place of abode) (If nonresident give city or town and State)  
 Length of residence in city or town where death occurred *5* yrs. — mos. — ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX *Female*  
 4. COLOR OR RACE *White*  
 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Widowed*  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Widowed*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Sep. 20. 1872*

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1	
				day, — hrs.	or — min.
<i>54</i>	<i>9</i>	<i>28</i>			

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work *Housework*  
 (b) General nature of industry, business, or establishment in which employed (or employer).....  
 (c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN) *Madison County Mo.*  
 (STATE OR COUNTRY)

10. NAME OF FATHER *Not known*

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

12. MAIDEN NAME OF MOTHER *Not known*

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

14. INFORMANT *Mrs. W. J. Lehr*  
 (Address) *2613 Palm St.*

15. JUL 10 1927  
 Filed..... 19.....  
*Maul Starckoff*  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *July 18. 1927.*  
 17. I HEREBY CERTIFY, That I attended deceased from *July 10<sup>th</sup> 1927* to *July 18<sup>th</sup> 1927* that I last saw him..... alive on *July 18<sup>th</sup> 1927*, and that death occurred, on the date stated above, at *12:15 P. m.*

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
*Bronchial Pneumonia*  
*115B*  
*107A* (duration) yrs..... mos. *8* ds.  
 CONTRIBUTORY (SECONDARY) *Pleurisy* (duration) yrs..... mos. *8* ds.

18. WHEREAS DISEASE CONTRACTED *1025*  
 IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH? *no* DATE OF.....  
 WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS.....  
 (Signed) *W. R. Kelly* M. D.  
*7/19. 1927* (Address) *2702 N. Grand Ave*  
 \*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 *Fredericktown Mo* DATE OF BURIAL *July 20 1927*

20. UNDERTAKER *Quedmyer* ADDRESS *39547-20*

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.

