

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

Do not use this space.

29874

*July*

1. PLACE OF DEATH

County *Cole*

Registration District No. *213*

File No. ....

Township .....

Primary Registration District No. *3014*

Registered No. *270*

City *Jefferson*

(No. ....) St. .... Ward) ....

2. FULL NAME

*Anna Sinderman*

(a) Residence. No. *1420 E. Miller* St., .... Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 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)

*Married*

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

*Frank Sinderman*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Aug - 9 - 1856*

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs or _____ min.
<i>71</i>	<i>2</i>	<i>10</i>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *at home*

(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) *Germany*

10. NAME OF FATHER

*Unknown*

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

(STATE OR COUNTRY) .....

12. MAIDEN NAME OF MOTHER

*Unknown*

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

(STATE OR COUNTRY) .....

14. INFORMANT *Frank Sinderman*

(Address) *J.C. Mo.*

15. FILED *Oct 24 27*

*R. O. Belford M.D.*  
REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Oct. 19 - 1927*

17. I HEREBY CERTIFY, That I attended deceased from *Oct 15 1927* to *Oct 19 1927* that I last saw her alive on *Oct 19 1927*, and that death occurred, on the date stated above, at *10 P.M.*

THE CAUSE OF DEATH WAS AS FOLLOWS:

*Bacterial Pneumonia*  
*59*  
*108* *57* (duration) yrs. mos. ds. *2 ds.*  
CONTRIBUTORY *diabetes.* (SECONDARY) (duration) *2 yrs.* mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, .....

DID AN OPERATION PRECEDE DEATH? *no.* DATE OF .....

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS? *clinical*

(Signed) *Jan A. Hill*, M. D.

*10-20-1927* (Address) *Trust oldy Jeffen City 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

*St. Petersbaw. J.C.* *10-22-1927*

20. UNDERTAKER

ADDRESS

*C.P. Heinrichs* *J.C. Mo.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. Amount of alcohol consumed should be carefully supplied.

3 1927

