

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

Do not use this space.

31480

1. PLACE OF DEATH

County Madison Registration District No. 1160
 Township Centerville Primary Registration District No. 4470
 City Linn City (No. 765 Harvard) St. Linn Ward

File No. 71
 Registered No. _____

2. FULL NAME

Annie Rothwell
 (a) Residence. No. 765 Harvard 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 OF (OR) WIFE OF Fountain Rothwell

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 25 1864

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
63 4 5

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife 50
 (b) General nature of industry, business, or establishment in which employed (or employer) 47
 (c) Name of employer 46

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Mo

10. NAME OF FATHER Green Harrington

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

12. MAIDEN NAME OF MOTHER Jane Gordon

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

14. INFORMANT Fountain Rothwell
 (Address) 765 Harvard

15. FILED Oct 2 1927 Leo R. Cull REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 1/27

17. I HEREBY CERTIFY, That I attended deceased from July 30 1927 to Sept 30 1927
 that I last saw her alive on Sept 30 1927, and that death occurred, on the date stated above, at 3:00 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Carcinoma of Media-
sternum & Bone

CONTRIBUTORY (SECONDARY) Carcinoma of breast

18. WHERE WAS DISEASE CONTRACTED

LF IF NOT AT PLACE OF DEATH: _____

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) Sam Bassett, M. D.
6/1, 1927 (Address) 5427 Delmar

*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

Valhalla Cemetery Oct 2 1927

20. UNDERTAKER ADDRESS

Fred M Williams 4561 Delmar

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.

10:00

Mr. J. Edgar Hoover
66-77-1000

JAN 19 1943