

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

Do not use this space.

31681

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City *St. Louis* No. *2040 A Division*

File No.

Registered No. **9023**

St. Ward)

2. FULL NAME

Bruna J. Anderson

(a) Residence, No. *2040 A Division* 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

1. SEX *Female* 4. COLOR OR RACE *Colored* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Mar 17-1902*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. *25 6 20*

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) (STATE OR COUNTRY) *Miss Mitchell Holloway*

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER *Anna Thompson*

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

14. INFORMANT *Sam Anderson* (Address) *2040 A Division*

15. OCT 10 1927 Filed *Man & Starrett* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *10-7-27*

17. I HEREBY CERTIFY That I attended deceased from *Oct 7 1927* to *Oct 7 1927* that I last saw h. alive on and that death occurred, on the date stated above, at *10:30 p.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Hemiplegia due to abscess of liver

CONTRIBUTORY (SECONDARY) *Hepatitis Abscess of liver cause alcoholic* (duration) yrs. mos. ds. *2*

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH *Miss*

Did an operation precede death? *no* DATE OF WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS (Signed) *W Moore*, M. D. *no* 1927 (Address) *1336 Franklin*

*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 *Washington Park* DATE OF BURIAL *10-11-27*

20. UNDERPAYER *W S No 20 m G Finney* ADDRESS *4202*

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.

