

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

Do not use this space.

17802

1. PLACE OF DEATH

County Marion
Township Mason
City Hannibal (Not Levee Haupt)

Registration District No. 547
Primary Registration District No. 3079

File No. _____
Registered No. 179
St. 67 Ward

2. FULL NAME

Anna Mathew Forney

(a) Residence. No. Tilden St Oakwood 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 (OR) WIFE OF Elnor Forney

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 25 1880

7. AGE: YEARS 48 MONTHS 2 DAYS 24 IF LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife
(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) Rolls Co Mo

10. NAME OF FATHER Wm F Wooley

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

12. MAIDEN NAME OF MOTHER Ruth Burns

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

14. INFORMANT Elnor H Forney (Address) Oakwood Mo

15. FILED 5/19 19 28 Cl Stone REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May-19 1928

17. I HEREBY CERTIFY, That I attended deceased from mo 21 1927 to May 19 1928 that I last saw her alive on 5-19 1928 and that death occurred, on the date stated above, at 6:00 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Parasitiasis of
pancreas
46F
(duration) yrs. 8 mos. ds.

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

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH: Her home Oakwood Mo
1. DID AN OPERATION PRECEDE DEATH? yes DATE of May 28 27
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) J J Bourne, M. D
5719 1928 Address Hannibal 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 Hydeburg DATE OF BURIAL May 20 1928

20. UNDERTAKER Wm M Smith ADDRESS Hannibal

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.

