

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

Do not use this space.

19141

**1. PLACE OF DEATH**

County.....

Registration District No. **791**

File No. ....

Township.....

Primary Registration District No. **1003**

Registered No. **5565**

City **St. Louis Mo.** (No. **St. Johns Hospital**) St. .... Ward)

**2. FULL NAME**

**Anna M. (Bauer) Bone**

(a) Residence. No. **4711 Wyoming** 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 **Edward Bone**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **June 14 1877**

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

**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) **at home**  
(c) Name of employer

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

10. NAME OF FATHER **Chas G. Ade**

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

12. MAIDEN NAME OF MOTHER **Dora Schieber**

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

14. INFORMANT **Edward Bone**  
(Address) **4711 Wyoming St.**

15. FILED **May 22 1928**

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **May 21 1928**

17. I HEREBY CERTIFY, That I attended deceased from **December 20, 1927, to May 21, 1928** that I last saw her alive on **May 21, 1928**, and that death occurred, on the date stated above, at **12:30 P.M.**

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

**Embolus of Brain**  
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) **Cholelithotomy operation for Gall Stones**  
(duration) yrs. mos. ds. **10**

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH: **I do not know**  
DID AN OPERATION RECEIVE DEATH: **yes**, DATE OF **April 30<sup>th</sup>**  
WAS THERE AN AUTOPSY: **no**

WHAT TEST CONFIRMED DIAGNOSIS: **Operation Etc.**  
(Signed) **W. Stuel**, M. D.  
, 19 (Address) **3271 Lucas Ave. St. Louis**

\*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 **Memorial Park** DATE OF BURIAL **May 23<sup>rd</sup>**

20. UNDERTAKER **Reubensrud Tnd Co** ADDRESS **4834**

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.

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