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

Do not use this space.

40906

1. PLACE OF DEATH
County: Jackson — Registration District No.: 399 — File No.:
Township: K. Kaw — Primary Registration District No.: 1002 — Registered No.: 5283
City: K. C. Mo. (No. 1624 Cornington Ave, St. Ward)

2. FULL NAME: Anna M. Telick

(a) Residence. No. 1624 Cornington St., 12 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: Fe
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Nov-5-1849

7. AGE: Years 79 | Months 1 | Days 14 | If LESS than 1 day, ..hrs. or ..min.

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): Penn

PARENTS
10. NAME OF FATHER: Sam'l Fitz
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY): Penn
12. MAIDEN NAME OF MOTHER: No Record
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY): No Record

14. INFORMANT: Sam'l Telick
(Address) 618 Hardy Ave.

15. FILED 12/20 1928 M. M. Crowe
Asst. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Dec. 19, 1928

17. I HEREBY CERTIFY, That I attended deceased from Dec. 8, 1928, to Dec. 15, 1928, that I last saw her alive on Dec. 15, 1928, and that death occurred, on the date stated above, at 1:45 PM m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pneumonia
Broncho.
100 A
(duration) yrs. mos. 14 ds.
CONTRIBUTORY (SECONDARY) Senility
(duration) 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 Signs
(Signed) H. D. Linthicum, M. D.
12/20, 1928 (Address) North Kansas 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: Leeds Ave., Mo. — DATE OF BURIAL: Dec 21, 1928
20. UNDERTAKER: Mrs. C. L. Foster — ADDRESS: K. C. Mo.

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.

WHEN PRINTED, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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