

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

Do not use this space.

495

1. PLACE OF DEATH

County Cape Girardeau Registration District No. 124 File No. _____
 Township Boyd Primary Registration District No. 15779 Registered No. 4
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

Anna Minnie Fluggie

(a) Residence, No. _____ St. _____ Ward _____
 (Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 3 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 Albert Wm Fluggie

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 22 1906

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1	
				day, _____ hrs.	or _____ min.
<u>22</u>	<u>3</u>	<u>24</u>			

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work House wife
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Near Frontland, Mo
 (STATE OR COUNTRY) _____

10. NAME OF FATHER Wm Mantz

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) Cape Girardeau Mo.

12. MAIDEN NAME OF MOTHER Christina Puckham

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) Near Oak Ridge Mo.

14. INFORMANT Wm Mantz
 (Address) Jackson Mt R #4

15. FILED 1417 29 D. G. Luber
 _____, 19____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 16 19 29

17. I HEREBY CERTIFY, That I attended deceased from _____
Jan 9 19 29, to Jan 16 19 29
 that I last saw her alive on Jan 15 19 29, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Phlebotomy
14 10 (duration) _____ yrs. _____ mos. 5 ds.
CONTRIBUTORY (SECONDARY) Premature Birth
7 1/2 months; Jan 15 (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED at home
 IF NOT AT PLACE OF DEATH, _____

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Physician's report
 (Signed) D. G. Luber, M. D.

1-17, 1929 (Address) Jackson 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 Lutheran Church Pili **DATE OF BURIAL** Jan 17 19 29

20. UNDERTAKER Wm Embury & Wood Co. **ADDRESS** Jackson Mo.

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.

1929
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