

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

Do not use this space. 10
4879-11
L
File No. _____
Registered No. **1389**
St. _____ Ward)

1. PLACE OF DEATH

County _____ Registration District No. **1001**
Township _____ Primary Registration District No. _____
City **St. Louis** (No. _____)

2. FULL NAME

ANNA TAVINAR
(a) Residence. No. **144 St. George** St. **23** Ward.
(Usual place of abode)

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 **Andrew Pytnar**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Dec 18 - 1877**

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	51	1	22	

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) **Poland**
(STATE OR COUNTRY)

10. NAME OF FATHER **Joseph Trosman**

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

12. MAIDEN NAME OF MOTHER **Rebecca Trosman**

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

14. INFORMANT **Andrew Pytnar**
(Address) **144 St. George**

15. FILED **-2** 1929
FILED _____ 19____
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Jan 30 1929**

17. I HEREBY CERTIFY, That I attended deceased from **Jan 30 1929** to **Jan 30 1929** that I last saw her alive on **Jan 30 1929**, and that death occurred, on the date stated above, at **2:50 p.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

820
Cerebral Hemorrhage
(duration) yrs. mos. / ds.

CONTRIBUTORY (SECONDARY) **740**
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED **740**
IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? **No** DATE OF _____

20. WAS THERE AN AUTOPSY? **No**

WHAT TEST CONFIRMED DIAGNOSIS **Micro**
(Signed) **William Baron**, M. D.
19____ (Address) **212 Hickory**

*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 **St. Peter & Paul** DATE OF BURIAL **Feb 4 1929**

20. UNDERTAKER **Central** ADDRESS **1841 Cass**

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.

WHITE PAPER, WITH UNFADING INK—THIS IS A PERMANENT RECORD

