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

Do not use this space.

8769

1. PLACE OF DEATH

County ..... Registration District No. 79 ..... File No. .....

Township ..... Primary Registration District No. 1003 ..... Registered No. 2443

City St Louis (No. 812 Madison St. ..... Ward)

2. FULL NAME Anna Hudson

(a) Residence. No. 812 Madison St., 26 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) Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 5 1845

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
83	8	16	

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

235

9. BIRTHPLACE (CITY OR TOWN) St Louis Mo.
(STATE OR COUNTRY)

1

PARENTS

10. NAME OF FATHER Solomon Ketchum

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

31

12. MAIDEN NAME OF MOTHER

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

31

14. INFORMANT Wm Hagerty
(Address) 1001 N. 13 St.

15. FILED FEB 23 1929 Max C Starkley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feby 21 1929

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19..... that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at 3 15 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar Pneumonia

108 (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) W. M. A.

(duration) ..... yrs. ..... mos. ..... ds.

101a

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? .....

8 DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) [signature], M.D.

2/23, 1929 (Address) Dexcity Coroner

*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 Bellefontaine Cemetery

DATE OF BURIAL 2/23 1929

20. UNDERTAKER Meek and Dickman

ADDRESS 3039 Easton

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.