

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

Do not use this space.

16296

**1. PLACE OF DEATH**

County.....  
Township.....  
City St. Louis

Registration District No. 791  
Primary Registration District No. 10003  
City City Hospital #2 (No. 2)

File No. 4335  
Registered No. 4335  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Emma Anderson

(a) Residence. No. 5647 Welle St. 6 Ward. \_\_\_\_\_  
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female 4. COLOR OR RACE Col. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
60

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work. Maad  
(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) Unknown

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Anna J. Woodard (Address) City Hospital #2

15. FILER 13 1929 May 2 St. Louis REGISTRAR

**2 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-12-1929

17. I HEREBY CERTIFY, That I attended deceased from 12-10-, 1928, to 4-12-, 1929, that I last saw h. per alive on 4-12-, 1929, and that death occurred, on the date stated above, at 10:01 A m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Chr. myocarditis  
137 (duration) \_\_\_\_\_ yrs. ? mos. da.  
73C  
CONTRIBUTORY Chr. nephritis  
(SECONDARY) (duration) \_\_\_\_\_ yrs. ? mos. da.

18. WHERE WAS DISEASE CONTRACTED 1290

IF NOT AT PLACE OF DEATH \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) T. E. Cunningham, M. D.

. 19 (Address) 2945 Jaxton

\*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 DATE OF BURIAL

Oak Dale Cemetery 4-13-1929

20. UNDERTAKER ADDRESS

Rom Green 3527 Leede

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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