

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

Do not use this space.

1. PLACE OF DEATH

County.....

Registration District No. 705

Township.....

Primary Registration District No. 703

City H. Louis, Mo.

(No. 5600, Arsenal)

File No. 16321

Registered No. 4360

St. 24th Ward

2. FULL NAME

Annie Mc Kinney
 (a) Residence. No. 1621 Franklin St. 25 Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 48 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

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Widow

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

Widow

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

March 22, 1841

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, _____ hrs. or _____ min.

88

0

21

8. OCCUPATION OF DECEASED

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

none

(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)

Ireland

10. NAME OF FATHER

McCulla

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.....
 (Address).....

L. O. Kroner
564 Arsenal

15.

FILED APR 15 1929

W. C. Carter

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

4/13 1929

17.

I HEREBY CERTIFY, That I attended deceased from 3/26, 1929, to 4/13, 1929. that I last saw her alive on 4/13, 1929, and that death occurred, on the date stated above, at 1:40 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Emphysema of lung (non-traumatic)
leg ulcer, chronic

CONTRIBUTORY (SECONDARY)

Myocarditis, chronic (duration) 19 mos. 19 da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?

DATE OF.....

WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS?

Culture, white (Signed)..... M. D.

4/13, 1929 (Address) 500 Arsenal St.

*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

Valley Cemetery

4-15-1929

20. UNDERTAKER

ADDRESS.....

B. J. Rogers and Co 3661 Wash. St.

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.

