

AUG 22 1924

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

Do not use this space.

23964

## 1. PLACE OF DEATH

County Callaway Co  
Township Walter  
City Fulton Mo

Registration District No. 104  
Primary Registration District No. 3008

File No. 136  
Registered No. 136  
St. \_\_\_\_\_ Ward \_\_\_\_\_

## 2. FULL NAME

(a) Residence No. Anna Hope  
Poplar Bluff Mo St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode)

Ohio Hospital No 1  
(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? 3 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

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

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
24 5 4 \_\_\_\_\_

## 8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Handlaper  
(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) \_\_\_\_\_

10. NAME OF FATHER W.C.

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

12. MAIDEN NAME OF MOTHER W.C.

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

14. INFORMANT Ohio Hospital No 1  
(Address) Fulton Mo

15. July 3, 1924 R. N. Crews  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 21 1924

17. I HEREBY CERTIFY, That I attended deceased from July 14 to July 21 1924  
(that I last saw h. alive on July 14, 1924, and that death occurred, on the date stated above, at \_\_\_\_\_ M.

THE CAUSE OF DEATH WAS AS FOLLOWS:

General Syncope of heart

CONTRIBUTORY (SECONDARY) Syncope (duration) 3 yrs. 4 mos. 4 ds.

18. WHETHER DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH \_\_\_\_\_  
DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS physical & laboratory

(Signed) R. N. Crews M. D.

, 19 (Address) Ohio Hospital No 1

\*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

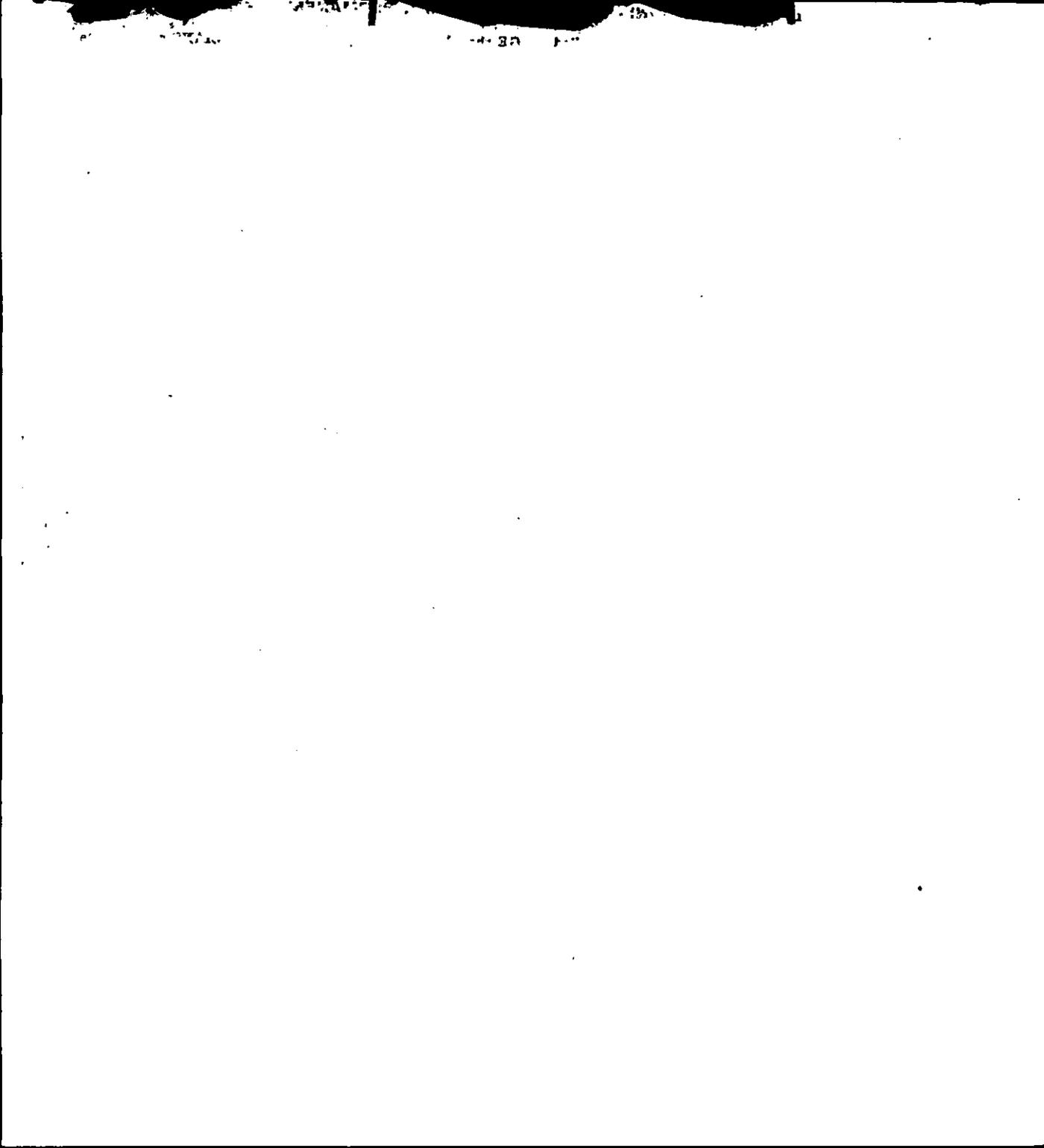
Kirksville Mo July 5 1924

20. UNDERTAKER

Chas. Bell ADDRESS Fulton Mo

N. B.—Every item of information 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.

35  
27  
31



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

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

1. PLACE OF DEATH  
 County Callaway Registration District No. 104 File No. ....  
 Township Fulton Primary Registration District No. 3008 Registered No. 136  
 City Fulton (No. ....) St. .... Ward)

2. FULL NAME Anna Haas  
 (a) Residence. No. .... St. .... 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 <u>F</u>	4. COLOR OR RACE <u>Col</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>m</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF				
6. DATE OF BIRTH (MONTH, DAY AND YEAR)				
7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, .... hrs. or .... min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work (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)				
PARENTS	10. NAME OF FATHER			
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)			
	12. MAIDEN NAME OF MOTHER			
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)				

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 2 1929

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

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

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

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

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

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

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed)....., M. D.

, 19 (Address)

\*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  
July 1 1929

20. UNDERTAKER ADDRESS

14. INFORMANT (Address)  
R. N. Crews  
 15. FILED July 3 1929 REGISTRAR

IS A PERMANENT RECORD  
 UNPAID  
 WRITE UP  
 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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-23964