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

Do not use this space.

25173

1. PLACE OF DEATH
County Linn
Township
City Marceline (No. ..... St. ..... Ward)

Registration District No. 502
Primary Registration District No. 4305

File No.
Registered No. 25

2. FULL NAME Anna Fiala

(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? 43 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Female	white	widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF → Frank Fiala Sr.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 5 1848

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	80	8	15	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work retired
(b) General nature of industry, business, or establishment in which employed (or employer) Housewife
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Lisca
(STATE OR COUNTRY) Bohemia

PARENTS
10. NAME OF FATHER Dont Know
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Bohemia
12. MAIDEN NAME OF MOTHER Dont Know
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Bohemia

14. INFORMANT Joe Fiala
(Address) Marceline Mo

15. FILED 7/25, 1929 Ola Putman REGISTRAR
R.L.

2) MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 20 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 5:00 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Marasmus 131 1322

..... (duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (SECONDARY) Influenza

..... (duration) 5 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) R M Cafer M. D.
7/23, 1929 (Address) Marceline Mo

*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 Mt Olivet
DATE OF BURIAL July 21 1929

20. UNDERTAKER Jas M Laughlin
ADDRESS Marceline Mo

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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