

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

Do not use this space.

26917

1. PLACE OF DEATH

County Butler Registration District No. 50
 Township _____ Primary Registration District No. 3004
 City Butler (No. _____) St. _____ Ward _____

File No. _____
 Registered No. 47

2. FULL NAME

Anna DeBow
 (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 female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan Dec 15, 1840

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
88 8 10

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work. Housewife
 (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) Ohio

10. NAME OF FATHER James Keeler

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Don't know

12. MAIDEN NAME OF MOTHER Don't know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Don't know

14. INFORMANT E. D. DeBow
 (Address) Butler Mo

15. FILED 8/26 1929 Nena L Culver
 REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 25 1929

17. I HEREBY CERTIFY, That I attended deceased from Aug 15, 1929, to August 25, 1929 that I last saw her alive on Aug 25, 1929, and that death occurred, on the date stated above, at 9:00 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Mitral regurgitation.
Aortic stenosis
92A
111B (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY pulmonary edema (SECONDARY) (duration) _____ yrs. _____ mos. 1 ds.

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?
 (Signed) Leo H. Kiehl, M. D.

827, 1929 (Address) Butler 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 Walc Hill DATE OF BURIAL Aug 27 1929

20. UNDERTAKER Culver's ADDRESS Butler Mo.

81 128
 7
 3
 4
 235
 2
 31
 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.

