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

Do not use this space.

35113

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. .....

Township ..... Primary Registration District No. 1003 Registered No. 9836

City St. Louis (No. City Hospital St. ..... Ward)

2. FULL NAME 10264 Anne Randolph

(a) Residence. No. 3715 Chouteau St. 18 Ward. (If nonresident, give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 6 — 1860

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	69	2	28	

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

235

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Georgia

PARENTS

10. NAME OF FATHER Jon Turner

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Hospital Information
(Address) Chouteau City Hospital

15. FILED OCT -5 1929 19 Max C. Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from Sept 30, 1929, to Oct 4 1929 that I last saw her alive on Oct 4 1929 and that death occurred, on the date stated above, at 2 30 pm.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
1. Cerebral Hemorrhage (L. Middle Cerebral Artery (2) Chr. Interstitial Nephritis (3) Chr. Myocarditis (4) Chr. Cholelithiasis (5) C.P.C. Spleen, Liver + Lungs. (duration) ..... yrs. ..... mos. ..... ds.

131 936 221

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

1290

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH 3715 Chouteau
DID AN OPERATION PRECEDE DEATH? no DATE OF ✓
WAS THERE AN AUTOPSY? yes
WHAT TEST CONFIRMED DIAGNOSIS? Autopsy

(Signed) Deny Margulies M. D.
10/4, 1929 (Address) City Hospital

*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
Valhalla Cemetery	Oct 7 1929
20. UNDERTAKER	ADDRESS
Wm Ambruster Und Co	4234 Manchester

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.

Randolph