

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

Do not use this space.

35116

1. PLACE OF DEATH

County..... Registration District No. 791
Township..... Primary Registration District No. 1003
City St. Louis, (No. City Hospital) St. Ward

File No.
Registered No. 9839
St. Ward

2. FULL NAME Anna Root,

(a) Residence. No. 111 Washington Hotel St. 13 Ward.
(Usual place of abode) 610 N. Washington (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) Widow
-------------------------	----------------------------------	--

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1868-7-17

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	61	2	17	

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) At home
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Mt. Sterling,
(STATE OR COUNTRY) Ky.

10. NAME OF FATHER Unknown

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) "

14. INFORMANT Bessie Smith
(Address) Washington Hotel

15. FILED 1003-5-1929 Max C. Starkloff
REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct. 4th, 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 10:10 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar Pneumonia following fractured Right Femur, due to fall to side-walk

186A (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 194R
108 Accident (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

8/18/29 **IF NOT AT PLACE OF DEATH**

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) J. W. Ferner M.D.

10/5/29. (Address) Def. Coron

*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 <u>Marissa, Ill.</u>	DATE OF BURIAL <u>10/6th, 29.</u>
--	--------------------------------------

20. UNDERTAKER <u>Robert Lamberton</u>	ADDRESS <u>456 E Washington</u>
---	------------------------------------

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.

223
2
31

