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

Do not use this space.

36506

1. PLACE OF DEATH
County: Callaway
Township: Callaway
City: Fulton
Registration District No. 104
Primary Registration District No. 3008
File No.
Registered No. 230
(No. ..... St. ..... Ward)

2. FULL NAME: Anna Kiser
(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 87 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: Widow
6. DATE OF BIRTH (MONTH, DAY AND YEAR): Dont Know
7. AGE: 87 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): Callaway Co

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

14. INFORMANT: Hosp. Records
(Address): Fulton Mo
15. FILED: Nov 10 1929 R. N. Creeis, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Nov 10 1929
17. I HEREBY CERTIFY, That I attended deceased from 10-2029, 19..., to 11-18-29, 19..., that I last saw her alive on 11-9, 1929, and that death occurred, on the date stated above, at 4 a.m.
THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic myocarditis
932
57A
(duration) ..... yrs. 1 mos. ..... ds.
CONTRIBUTORY (SECONDARY): Artic Rheumatism
(duration) 1 yrs. ..... mos. ..... ds.
18. WHERE WAS 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?
(Signed) E. T. McTaugh, M. D
, 19 (Address) Fulton 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: Parkland Mo
DATE OF BURIAL: Nov 11 1929
20. UNDERTAKER: Herndon & Taylor
ADDRESS: Fulton 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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