

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

Do not use this space.

37629

1. PLACE OF DEATH

County Knox
Township North
City Knox City Mo. (No. _____)

Registration District No. 444
Primary Registration District No. 4262

File No. _____
Registered No. 14
St. _____ Ward _____

2. FULL NAME Maxine Bate Anthony

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 18 - 1929
7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
4 6

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) Knox City Mo.
(STATE OR COUNTRY)

10. NAME OF FATHER John Anthony
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Firkeville Mo.
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Ethel Davis
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Stahl Mo.
(STATE OR COUNTRY)

14. INFORMANT John Anthony
(Address) Knox City Mo.

15. FILED 1/23/30 1929 & J. R. Northcutt
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 23 1929

17. I HEREBY CERTIFY, That I attended deceased from Nov 23 1929 to Nov 23 1929 that I last saw him alive on Nov 23 1929, and that death occurred, on the date stated above, at 1:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

B - Pneumonia
16 yrs 10 mos 2 ds (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) _____ (duration) 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) W. H. McPherson M. D.
Nov 24 1929 (Address) Spring City 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 Pock Creek Cemetery DATE OF BURIAL Nov 23 1929
20. UNDERTAKER J. W. Hudson ADDRESS Edinburg Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

