

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

Do not use this space.

38480

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City *St. Louis* (No. *St. Johns Hosp*)
 File No. Registered No. **10870**
 St. Ward)

2. FULL NAME

Anna Regna
 (a) Residence. No. **4039A Bataillon ave St.** **17** Ward. (if nonresident give city or town and State)
 (Usual place of abode)
 Length of residence in city or town where death occurred **33** yrs. mos. ds. How long in U.S., if of foreign birth? **33** yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* **4. COLOR OR RACE** *White* **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** *married*
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Paul Regna*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *May 1, 1868*

7. AGE YEARS MONTHS DAYS **IF LESS than 1 day, hrs. or min.**
61 *6* *4*

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)

(STATE OR COUNTRY) *Italy*

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) *Italy*

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) *Italy*

14.

INFORMANT *Gemma Regna*
(Address) *4039A Bataillon ave*

15.

FILED *Nov 17 1929* **REGISTRAR**

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Nov 5* 19 *29*

17. I HEREBY CERTIFY That I attended deceased from *1924*
6 11 5 19 *29* *Nov 5* 19 *29*
 that I last saw h. alive on *Nov 5* 19 *29*, and that death occurred, on the date stated above, at *12:30 A.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral hemorrhage and attach
12:30
8:20 (duration) yrs. mos. *4* ds.
CONTRIBUTORY (SECONDARY) *High Blood Pressure*
Chronic valvular neph. (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED?

IF NOT AT PLACE OF DEATH, DATE OF.....
 DID AN OPERATION PRECEDE DEATH, DATE OF.....
 WAS THERE AN AUTOPSY.....
 WHAT TEST CONFIRMED DIAGNOSIS *Chromal Microscope*
Chromal Microscope (Signed)..... M. D.
 , 19 (Address) *1035 Miron Blvd*

*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

Cahans Cemetery *11 7* 19 *29*

20. UNDERTAKER

ADDRESS

Friegehaus & Co *Highway*

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

335
16

111 cases of ...
Mott's ...

12-2