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

Do not use this space.

39117

1. PLACE OF DEATH

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

Township ..... Primary Registration District No. 1003 Registered No. 11599

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

2. FULL NAME Anna L. Crane

(a) Residence. No. 1700 Glenn Court Drive 11 Ward. St. Louis Co. Mo.
(Usual place of abode) (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	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 John Crane.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 13, 1871

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	58	10	12	

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 At Home.

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY) St. Louis, Mo.

PARENTS

10. NAME OF FATHER Joseph Tobin

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

12. MAIDEN NAME OF MOTHER Mary Connors

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

14. INFORMANT Margaret Crane
(Address) 1700 Glenn Court Drive

15. FILED 27 19 Max C Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 25 1929

17. I HEREBY CERTIFY, That I attended deceased from Nov. 25, 1929, to Nov. 25, 1929, that I last saw her alive on Nov. 25, 1929, and that death occurred, on the date stated above, at 5.30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Hemorrhage.
88 A (Apoplexy)

..... (duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (SECONDARY) Cyanosis

..... (duration) ..... yrs. ..... mos. 1 ds.

18. WHERE WAS DISEASE CONTRACTED? 7 Mo.

IF NOT AT PLACE OF DEATH .....

DID AN OPERATION PRECEDE DEATH? No DATE OF .....

WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS? Symptoms.

(Signed) Herman L. Watson, M. D.

Nov. 26, 1929 (Address) 2728 N. 11

*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
Calvary	Nov. 28 1929
20. UNDERTAKER	**ADDRESS**
Bensieck-Kiehaus	1138 N. 6th

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.

Dr. H. L. Weiter
2728 91. 11. ER

9-10 [illegible]