JAN 20 1929

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

Do not use this space.

Freeman

40361

File No. .....

Registered No. 960

1. PLACE OF DEATH

County Greene — Registration District No. 318

Township ..... — Primary Registration District No. 2091

City Springfield (No. 1625 N. Campbell St. ..... Ward)

2. FULL NAME Anna Lahey

(a) Residence. No. 1625 N. Campbell St., ... Ward. .....
(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	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 22 - 1912

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	17	8	8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(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) Mo.

PARENTS

10. NAME OF FATHER Tom Burt

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

12. MAIDEN NAME OF MOTHER Mary Rogers

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

14. INFORMANT ~~Mrs.~~ Ralph Lahey
(Address) Springfield, Mo.

15. FILED 12-31, 1929 Lon Sharp REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 30 1929

17. I HEREBY CERTIFY, That I attended deceased from Nov 15, 1929, to Dec 30, 1929, that I last saw her alive on Dec 28, 1929, and that death occurred, on the date stated above, at 9:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Valvular Disease of Heart

(duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (SECONDARY) ..... (duration) ..... 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? Clinical

(Signed) S. F. Mann, M. D.

12/31, 1929 (Address) Springfield 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 Green Lawn Cemetery — DATE OF BURIAL Jan 1 1930

20. UNDERTAKER J. W. Klingner 424 E. Court St. Springfield Mo. — ADDRESS

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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