

MAR 25 1930

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

Do not use this space.

4169

1. PLACE OF DEATH

County..... Buchanan
Township.....
City..... St. Joseph, (No. St. Joseph's Hospital

85

Registration District No.....
Primary Registration District No. 1001

File No. 239
Registered No. 239
St. Ward)

2. FULL NAME

Anna Cottrell

(a) Residence. No. R.F.D.#7. City. St. Ward.

Length of residence in city or town where death occurred 3 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 Female
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

Ellis Cottrell

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown, 1886

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
43 Unknown

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home.
(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) Paris, Ky.

PARENTS

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Ellis Cottrell

Address R.F.D.#7.

15. FILED FEB 25 1930 John S. [Signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 23, 1930 19

17. I HEREBY CERTIFY That I attended deceased from 2-19 10:22-23 30. that I last saw her alive on 2-22 30, and that death occurred, on the date stated above, at 5.15 A.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Empyema of Left Bladder
1930
1930

(duration) yrs. mos. 4 ds.
CONTRIBUTORY (SECONDARY) Myocarditis Chr. unknown
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT A PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE OF 2/21/30

WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS? Clinical (Signed) O. S. [Signature] M. D.

2/24/30 (Address) 1011 [Address]
*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

Ashland Cemetery

DATE OF BURIAL

Feb. 25, 19 30

20. UNDERTAKER

Walter Meierhoffer

ADDRESS 1302 Faraon St.

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.

