

MISSOURI STATE BOARD OF HEALTH

Do not use this space.

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1. PLACE OF DEATH

County FranklinTownship CentralCity SpringfieldRegistration District No. 218Primary Registration District No. 5439(No. P.S.D. 1)File No. 4709Registered No. 124

St. _____

Ward) _____

2. FULL NAME Mrs. Anna Kennel

(a) Residence. No. _____ St. _____ Ward. _____

(Usual place of abode)

(if nonresident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. _____ mos. _____ ds.

How long in U.S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female4. COLOR OR RACE W5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Earnest Kennel6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 31 1849

7. AGE

YEARS 87MONTHS 5DAYS 6

IF LESS than 1 day, _____ hrs. or _____ min.

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) _____

(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Germany

(STATE OR COUNTRY)

10. NAME OF FATHER Louis Meck

PARENTS

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Germany

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Julia King13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Germany

(STATE OR COUNTRY)

14.

INFORMANT Earnest Kennel
(Address) P.S.D. 1

15.

FILED 2-10-301930John Sharp

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-7-30

17.

I HEREBY CERTIFY, That I attended deceased from 2-6-30 to 2-7-30 and that I last saw him alive on 2-6-30, and that death occurred, on the date stated above, at 7:30 AM.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Olderney of Lung
resulting from
Valvular Bronchitis

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED POW

IF NOT AT PLACE OF DEATH _____

C DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) H. H. Freenger, M. D.19 (Address) Springfield Mo.

*State the DISEASE CAUSING DEATH, in all 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 TruemanDATE OF BURIAL 2-19-3020. UNDERTAKER W. H. CarverADDRESS Springfield Mo.

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.

MAR 25 1930

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