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

Do not use this space.

File No. 6865
Registered No. 1703

1. PLACE OF DEATH

County ..... Registration District No. 791
Township ..... Primary Registration District No. 1003
City St Louis (No. Deaconess Hospitial St. ..... Ward)

2. FULL NAME Anna Ranson

(a) Residence. No. 3960 a McRee St., 17 Ward.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 30 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	Single.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 16 1858

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
71.	6.	29.	

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) at Home.
(c) Name of employer Self

9. BIRTHPLACE (CITY OR TOWN) Keokuk
(STATE OR COUNTRY) Iowa.

PARENTS
10. NAME OF FATHER Thomas Ranson
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Irland
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Ellen Neely
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Irland

14. INFORMANT Joseph Ranson
(Address) 3960 a McRee

15. FILED Feb 18, 19.. Max C. Starkloff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feby 15th 1930

17. I HEREBY CERTIFY, That I attended deceased from October 10th, 1929, to Feby 14th, 1930 that I last saw her alive on Feby 14th, 1930, and that death occurred, on the date stated above, at 5:10 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Myocarditis chronic
130
93C
(duration) yrs. 6 mos. ds.

CONTRIBUTORY (SECONDARY) Nephritis Chronic
(duration) yrs. 6 mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH at home
DID AN OPERATION PRECEDE DEATH? no. DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Clinical symptoms
(Signed) Carl J Kaantz, M. D.
Feby 16th 1930 (Address) 414 Wesley ave Ferguson 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 Keokuk Iowa
DATE OF BURIAL Feb 19 1930

20. UNDERTAKER McLaughlin
ADDRESS 1631 Missouri

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.

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