

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

Do not use this space.

10434

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... File No.
 City St. Louis No. Missouri Baptist chm. Registered No. 2416
 (Usual place of abode) (If nonresident, give city or town and State) Ward)

2. FULL NAME

Anna Lee Chiles
 (a) Residence No. 6600 Washington St., 12 Ward. St. Louis 20 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 Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 3-1862

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
67 6 6

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Missionary Work
 (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.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

14.

INFORMANT Jane M. Claine

(Address) 4339 Selmar

15.

FILED 11 19 May 10 J. J. J. J. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar-9-1930

17. I HEREBY CERTIFY, That I attended deceased from Feb 22 1930 to Mar 9 1930 that I last saw him alive on Mar 8 1930, and that death occurred, on the date stated above, at 8:10 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrhage

CONTRIBUTORY Hyperextension Arterio Sclerosis (duration) yrs. mos. ds.

18. WHERE DISEASE CONTRACTED Mo. IF NOT AT PLACE OF DEATH

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

20. WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Cerebral
 (Signed) Clare Abel M. D.

3/10/1930 (Address) 3701 Washington Pl

*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 Washington Mo. DATE OF BURIAL 3/11/1930

20. UNDERTAKER Lewis H. Bopp ADDRESS Birkwood Mo.

WHITE 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.

