

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

Do not use this space.

16255

**1. PLACE OF DEATH**

County Jackson Registration District No. 399  
Township St. Louis Primary Registration District No. 1002  
City St. Louis (No. 3937) Wayne

File No. 21 13  
Registered No. 21 13  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Annie Carter  
(a) Residence. No. 3937 Wayne St., 13 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 <u>Female</u>		4. COLOR OR RACE <u>Col</u>		5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>wid</u>	
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF					
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Oct 16 - 1864</u>					
7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.	
	<u>65</u>	<u>7</u>	<u>1</u>		
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. <u>Domestic</u> (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) <u>Howard Mo</u>					
PARENTS	10. NAME OF FATHER <u>Louis Wright</u>				
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Mo</u>				
	12. MAIDEN NAME OF MOTHER <u>M. Wright</u>				
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Mo</u>				
14. INFORMANT <u>Mable Milton</u> (Address) <u>1412 Kensington</u>					
15. FILED <u>9/21 1930</u> <u>M. M. Crowe</u> REGISTRAR					

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-18-1930

17. I HEREBY CERTIFY, That I attended deceased from Nov 7 1930 that I last saw her alive on Nov 10 1930 and that death occurred, on the date stated above, at 11:30 p. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
apoplexy  
82A  
Cerebral Hemorrhage (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTOR (SECONDARY) \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18. WHERE WAS DISEASE CONTRACTED \_\_\_\_\_  
IF NOT AT PLACE OF DEATH \_\_\_\_\_  
DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_  
WAS THERE AN AUTOPSY? \_\_\_\_\_  
WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_  
(Signed) E. M. Brown, M. D.  
May 17 1930 (Address) 1705 E 12

\*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 Highland Cem DATE OF BURIAL 5-21 1930

20. UNDERTAKER H. O. Moore ADDRESS 1820 E 18

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.

Gr. id. w. series  
1705 & 1211 -