

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.

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

Do not use this space.

18417

1. PLACE OF DEATH

County Harrison Registration District No. 882
Township Hickory Grove Primary Registration District No. 6174
City (No.) St. Ward)

2. FULL NAME

Anna Seger
(a) Residence. No. St. Ward.
(Usual place of abode)
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. (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) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 10 - 1863

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
67 2 20

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Household duties
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) St. Louis
(STATE OR COUNTRY) MO

10. NAME OF FATHER Henry Seger

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

12. MAIDEN NAME OF MOTHER Minna Mulhaupt

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

14. INFORMANT Eddie Seger
(Address) Quincy City MO

15. FILED 5/3/30 1930 G. A. Thesmer REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 1st 1930

I HEREBY CERTIFY, That I attended deceased from Jan 1st 1930 to May 1st 1930, 1930, that I last saw her alive on Apr 28th 1930, and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Interstitial Nephritis
131

(duration) yrs. mos. ds.

CONTRIBUTOR (SECONDARY) 1290
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH No

DID AN OPERATION PRECEDE DEATH? No DATE OF

19. WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) M. J. Clarenbach, M. D.
73 1930 (Address) Knight City 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 Knight City Cemetery DATE OF BURIAL 5/3 1930

20. UNDERTAKER Ch. Wilson ADDRESS Knight City MO

109

24

10

JUN 28 1930

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