

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

Do not use this space.

20667

~~20465~~

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City *St. Louis, Mo.*

(No. *City* *Superior* *St. Louis* *Mo.*)

File No.....

Registered No. **5448**

Ward.....

2. FULL NAME *Annie Florkers*

(a) Residence. No. *City* *St. Louis* *Mo.* St. **13** Ward.....

(If not resident, 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)

Unmarried

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Feb. 15, 1857*

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, hrs. or min.

73 yrs

3

17

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *none*

(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) *Ohio*

10. NAME OF FATHER *? cont. Know*

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) *" "*

12. MAIDEN NAME OF MOTHER *Annie Hartman*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) *Ohio*

14. INFORMANT *M. E. Redeker*

(Address) *5806 Arsenal*

15. FILED *Nov 1 1930*

Wm C Starke
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *June 2* 19*30*

17. I HEREBY CERTIFY, That I attended deceased from *June 1*, 19*30*, to *June 2*, 19*30* that I last saw h. *al* alive on *June 2*, 19*30*, and that death occurred, on the date stated above, at *7:30* p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

*Chronic Myocarditis
Chronic Nephritis*

CONTRIBUTORY (SECONDARY) *Senility*

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH *1290*

18. DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) *W. H. Hubbell*, M. D.

6-3-30 (Address) *5600 Arsenal*

*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

DATE OF BURIAL

Calvary

June-5 19*30*

20. UNDERTAKER

Edw. J. Howard & Sons

ADDRESS *4212 St. Louis Ave*

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.

