

NOV 3 1930

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

Do not use this space.

1. PLACE OF DEATH *St. Louis*
 County *St. Louis* Registration District No. *1170*
 Township *Richmond 15th* Primary Registration District No. *6248#* File No. *31078*
 City *St. Louis* (No. *St. Marys Hospital*) Registered No. *227*
 St. _____ Ward _____

2. FULL NAME *Anna A. Adams*
 (a) Residence No. *Courtenelle 225* 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) *Married*
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Victoria Adams*
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Unknown*
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
about 80
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work _____
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Sept 11, 1930*
 17. I HEREBY CERTIFY, That I attended deceased from *8-11-1930* to *9-12-1930* that I last saw her alive on *9-12-1930*, and that death occurred, on the date stated above, at *9* m.
 THE CAUSE OF DEATH* WAS AS FOLLOWS:
80 Syphilis (Tubes)
34
730 (duration) *15* yrs. _____ mos. _____ ds.
 CONTRIBUTORY (SECONDARY) *myocardia* (duration) *10* yrs. _____ mos. _____ ds.
 18. WHERE WAS DISEASE CONTRACTED *Illinois*
 IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH? *no* DATE OF _____
 WAS THERE AN AUTOPSY? *no*
 WHAT TEST CONFIRMED DIAGNOSIS *Clinical*
 (Signed) *Carl G. Erick* M.D.
 _____, 19 _____ (Address) *Webster Groves, Mo*

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

PARENTS

10. NAME OF FATHER *Hickel*
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Unknown*
 (STATE OR COUNTRY) _____
 12. MAIDEN NAME OF MOTHER *"*
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Ills*
 (STATE OR COUNTRY) _____

*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.

14. INFORMANT *Mrs. C. H. Brown*
 (Address) *4000 Lindell Pl*

15. FILED *9/13* 19. *30* *C. L. Jensen* REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Darway County* DATE OF BURIAL *Sept 15 1930*
 20. UNDERTAKER *C. L. Straight* ADDRESS *4259 1/2 Fair*

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.

648 E. Blvd

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