

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

Do not use this space.

**1. PLACE OF DEATH**

County.....

Registration District No.....

**791**

Township.....

Primary Registration District No.....

**1008**

City.....

(No. **2318<sup>a</sup> Sullivan Ave**)

File No. **34871**

Registered No. **10267**

St. .... Ward)

**2. FULL NAME**

*Johanna Anna*

(a) Residence, No. **2318<sup>a</sup> Sullivan Ave St.**, **20** 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

*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

*Edward Anna*

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

*Jan. 8, 1901*

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, ..... hrs. or ..... min.

*29*

*9*

*19*

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

*Housewife*

(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

*John Higgins*

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

*New Hampshire*

12. MAIDEN NAME OF MOTHER

*Ann Katz*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

*New York City, New York*

14.

INFORMANT

*Edward Anna*

(Address)

*2318<sup>a</sup> Sullivan Ave*

15.

FILED

*OCT 29 1930*

REGISTRAR

*Mar C. [Signature]*

REGISTRAR

**2. MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR)

*Oct 27 1930*

17.

I HEREBY CERTIFY, That I attended deceased from

*Oct 27*

19*30*, to *Oct 27*, 19*30*.

that I last saw h. *alive* on *Oct 27*, 19*30*, and that death occurred, on the date stated above, at *5:40 P.M.*

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

*8 1/2 Epilepsy*  
*14 1/2*

(duration) *8* yrs. .... mos. .... ds.

CONTRIBUTORY (SECONDARY)

*Pregnancy*

(duration) .... yrs. *9* mos. .... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? *Yes* DATE OF

WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS

(Signed)

*A. H. [Signature]*

M. D.

*10/28, 1930* (Address)

*2342 [Address]*

\*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

*Calvary Cemetery*

DATE OF BURIAL

*Oct 30 1930*

20. UNDERTAKER

*Goodhart & Goodhart*

ADDRESS

*2228 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.

WRITE COMPLETELY WITH WRITING INK—THIS IS A PERMANENT RECORD

