

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.

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

Do not use this space.

Dr B. Baccam

NOV 28 1930

37154

1. PLACE OF DEATH

County *St. Charles* Registration District No. *757*
Township *St. Charles* Primary Registration District No. *5998*
City (No. *Bucktown Road*) St. Ward

File No. _____
Registered No. *181*

2. FULL NAME

Anna Humble

(a) Residence. No. _____ St. _____ 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) *Single*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Oct 4 - 1846*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
64 0 27

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

9. BIRTHPLACE (CITY OR TOWN) *Portage des Sioux*
(STATE OR COUNTRY) *Mo*

10. NAME OF FATHER *Humble*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *No History*

12. MAIDEN NAME OF MOTHER *No History*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *No History*

14. INFORMANT *Mary Prinsater*
(Address) *323 South Second St.*

15. FILED *11/28*, 19 *30* *By J. Baccam*
REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Nov 1* 19 *30*

17. I HEREBY CERTIFY, That I attended deceased from *October 18*, 19 *30*, to *Nov 1*, 19 *30* that I last saw *h. h.* alive on _____, 19 _____, and that death occurred, on the date stated above, at *4:30 a. m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Septicemia
Chronic Pulmonary (Ck.)

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH *no knowledge*

DID AN OPERATION PRECEDE DEATH? *no* DATE OF _____

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS *Physical Exam.*

(Signed) *O. Gust G. G.*, M. D.

Nov 1, 19 *30* (Address) *200 Clay St St Charles 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 *St Petrus Cemetery* DATE OF BURIAL *Nov 2* 19 *30*

20. UNDERTAKER *W. D. Williams & Sons Co* ADDRESS *114 Maple Ave*

