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

Do not use this space.

7566

1. PLACE OF DEATH

County ..... Registration District No. 791 1003

Township ..... Primary Registration District No. ..... File No. .....

City St Louis Mo (No. City Hospital #2 St. ..... Ward) Registered No. 1922

2. FULL NAME Annie Rolland

(a) Residence. No. 2709 Walnut St., 22 Ward. (If nonresident, give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	Col	Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1-24-1890

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	41		14	

8. OCCUPATION OF DECEASED

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

(b) General nature of industry, business, or establishment in which employed (or employer) 2 34

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Miss
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT A Gertrude Creath
(Address) City Hospital #2

15. FILED 13 1931 19 Max C. Harvey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-8 1931

17. I HEREBY CERTIFY, That I attended deceased from 1-31, 1931, to 2-8, 1931 that I last saw her alive on 2-8, 1931, and that death occurred, on the date stated above, at 9 45 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: P.

Generalized Peritonitis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (SECONDARY) Hysterectomy for Benign Fibroid of Uterus

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? Yes DATE OF 2/4/31

WAS THERE AN AUTOPSY? (Hysterectomy for fibroid)

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) H. H. Weathers, M. D.

2/9, 1931 (Address) Hosp #2

*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 Fairview Jackson

DATE OF BURIAL 2-13-1931

20. UNDERTAKER J. S. Wade Mnd Co

ADDRESS 4202 Finney

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.

THIS IS A PERMANENT RECORD