

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

Do not use this space.

15860

1. PLACE OF DEATH

County.....
Township.....
City *St. Louis*

Registration District No. *701*
Primary Registration District No. *703*
(No. *5015* *Pennsylvania ave* St. Ward)

File No.
Registered No. *4319* St. Ward)

2. FULL NAME *Anna H. DeKines*

(a) Residence, No. *5015* *Pennsylvania* St. *14* Ward.
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred *3* 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*
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Sept 24, 1866*
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
64 6 13

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Housewife*
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Middleton Delaware*

13. NAME *Samuel Sartor*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Maryland*

15. MAIDEN NAME *Isabella Smith*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Maryland*

17. INFORMANT *William De Kines*
(ADDRESS) *5015 Pennsylvania*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Valhalla Cem* DATE *4-9-1937*

19. UNDERTAKER *Knightheadery and Co*
(ADDRESS) *422 1/2 So. Pine St. St. Louis*

20. FILED *W. H. C. ...* Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *4-6-1937*

22. I HEREBY CERTIFY, That I attended deceased, from *4-6-31*, 1937, to *4-6-31*, 1937.
I last saw him alive on *4-6-31*, 1937. Death is said to have occurred on the date stated above, at *5:45* P.m.
The principal cause of death and related causes of importance were as follows:

Chronic myocarditis
930
736
80-81
Other contributory causes of importance:
cerebral hemorrhage
3 yrs ago
Name of operation *none* Date of
What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? *no* Date of injury
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury *None*
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) *W. C. Pfeiffer* M. D.
(Address) *45235 Knightheadery*

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.

