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

Do not use this space.

16032

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City St Louis (No. Christian Hosp. St. ..... Ward)

File No. .....

Registered No. 4508

2. FULL NAME Anna Belle Burns

(a) Residence. No. 3806 Council Grove 9 Ward. Pine Lawn Mo.
(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Female	White	Married

5A. IF MARRIED, ~~WIDOWED~~, OR ~~DIVORCED~~ ~~HUSBAND~~ OF (OR) WIFE OF Wm. E. Burns

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 18-1898

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	33	2	25	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife 235

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Pittsburg
(STATE OR COUNTRY) Pennsylvania 23

PARENTS

10. NAME OF FATHER Don't know.

11. BIRTHPLACE OF FATHER (CITY OR TOWN) ?
(STATE OR COUNTRY) Don't know. 31

12. MAIDEN NAME OF MOTHER Don't know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ?
(STATE OR COUNTRY) Don't know

14. INFORMANT Mr. Wm. E. Burns
(Address) 3806 Council Grove Ave

15. FILED 11 1931 19 Max C. Stanley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-13- 1931

17. I HEREBY CERTIFY, That I attended deceased from 4-7-31, 19 ..., to 4-13, 1931 that I last saw her alive on 4-12, 1931, and that death occurred, on the date stated above, at 8 00 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Puerperal Septicemia
145A
149B

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (SECONDARY) Forceps Delivery

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? Yes DATE OF 4-7-31

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Physical findings

(Signed) C. M. Elvaire M. D.

, 19 (Address) 4356 Warne

*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	DATE OF BURIAL
Valhalla Cemetery	4-15 1931
20. UNDERTAKER	**ADDRESS**
Geo. L. Pleitsch	5961 Easton 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 PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD