

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

Do not use this space.

24945

**1. PLACE OF DEATH**

County.....  
Township.....  
City..... *St. Louis* (No. ....)

Registration District No. *702*  
Primary Registration District No. *7008*

File No. ....  
Registered No. *7121*  
St. .... Ward)

**2. FULL NAME**

*Annie Harker*  
(a) Residence No. *1439 Arlington Ave* 6 Ward.  
(Usual place of abode)

Length of residence in city or town where death occurred *40* 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) *Widowed*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *DEC 23 1850*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
*81 7 7*

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work *Nurse*  
(b) General nature of industry, business, or establishment in which employed (or employer).  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Penn*

10. NAME OF FATHER *Thos Glenn*

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

12. MAIDEN NAME OF MOTHER *Katie O'Flynn*

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

14. INFORMANT *Geo Glenn*  
(Address) *1439 Arlington Ave*

15. FILED *AUG - 1 1932* REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *July 30 1932*

17. I HEREBY CERTIFY, That I attended deceased from *July 30 1932* to *July 30 1932*  
that I last saw h.w. alive on *July 30 1932* and that death occurred, on the date stated above at *8:00 P.M.* m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

*Septic's Chronic*  
*131*  
*106B* (duration) yrs. *4* mos. ds.  
CONTRIBUTORY *Senile bronchitis*  
(SECONDARY) *1* (duration) yrs. *4* mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH *at place of death*

0 DID AN OPERATION PRECEDE DEATH DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS  
(Signed) *R. A. Thompson* M. D.

, 19 (Address) *2637*

\*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 *Grubville Mo* DATE OF BURIAL *Aug 2 1932*

20. UNDERTAKER *Jo Musville* ADDRESS *2637 Hickory St*

A. 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.

RECORD

