

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

Do not use this space.

41441

1. PLACE OF DEATH

County.....
Township.....
City..... (No.) Ward.....
Registration District No.
Primary Registration District No.

File No.
Registered No. **10443**
St. Ward)

2. FULL NAME. *Anna Lively*
(a) Residence, No. *1314 1/2 Benton St.* *26* Ward. (If nonresident, give city or town and State)
Length of residence in city or town where death occurred *9* 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) *separated*
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Sept. 1, 1890*

7. AGE — YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
43 2 0

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Housework*
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 1/2*

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Germany*

MOTHER 13. NAME *August Schmidt*

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

15. MAIDEN NAME *Marie Schmidt*

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

17. INFORMANT *Leonard Burns* (ADDRESS) *560 Arsenal*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Trieden* DATE *Dec 5th 1933*

19. UNDERTAKER *Stroth & Carroll Unders* (ADDRESS) *4600 Kate Bridge ave*

20. FILED *-5 1933* 19 *J. T. Bedeck* Registrar.

4 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Dec 1, 1933*

22. I HEREBY CERTIFY, that I attended deceased from *Sept 30 1933* to *Dec 1, 1933*
I last saw him alive on *Dec 1, 1933*. Death is said to have occurred on the date stated above, at *1:30 p.m.*

The principal cause of death and related causes of importance were as follows:

Typhoid Fever Date of onset *9-9*
Bronchopneumonia
Other contributory causes of importance:
Chronic Myocarditis

Name of operation *Cholecystectomy* Date of *11-15-33*
What test confirmed diagnosis? *Chemical* Was there an autopsy? *No*

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? *No* Date of injury 19.....
Where did injury occur? *No* (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
Nature of injury.....

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

(Signed) *John Eschenbrenner*, M. D.
(Address) *ISOLATION HOSPITAL*

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

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