

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.

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

Do not use this space.

1. PLACE OF DEATH

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

Registration District No. 791
Primary Registration District No. 1003

File No. 7222
Registered No. 2105
St. Ward)

2. FULL NAME

Annie M. Clemens
(a) Residence, No. 4374 W. Bell Pl St. 11 Ward.

(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 Female 4. COLOR OR RACE col 5. ~~Single~~ Married, WIDOWED, OR DIVORCED (write the word) Widow

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 15-1860

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>73</u>	<u>4</u>	<u>11</u>	

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. House work
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) Charleston (STATE OR COUNTRY) S.C.

MOTHER FATHER
13. NAME Not known

14. BIRTHPLACE (CITY OR TOWN) Unknown (STATE OR COUNTRY)

15. MAIDEN NAME Maryann Benja

16. BIRTHPLACE (CITY OR TOWN) Charleston (STATE OR COUNTRY) S.C.

17. INFORMANT Nemitta Robison Sister (ADDRESS) 4374 W BELL PL

18. BURIAL, CREMATION, OR REMOVAL PLACE St Peter's Cemetery DATE Mar 1 1934

19. UNDERTAKER Sneed P Randle (ADDRESS) 920 N LEONARD AVE

20. FILED JAR 1934 J. Bredeck Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 26 1934

22. I HEREBY CERTIFY, That I attended deceased from 19....., to 19.....

I last saw h..... alive on 19..... Death is said to have occurred on the date stated above, at 6:00 a.m.

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

Chronic Myocarditis
Sanility
W. A. C.
Date of onset

Other contributory causes of importance:

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide?..... Date of injury..... 19.....

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.....

Nature of injury.....

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

(Signed) [Signature] (Address) [Address]

7/27/34

