

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.

AUG 9 1935

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

Do not use this space.

24427

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City *St. Louis* (No. *1620, Carroll*)

File No.....
Registered No. **5801**
St. (Ward)

2. FULL NAME

Anna Lacy
(a) Residence, No. *1209 Missouri* St. *23* Ward.

(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 *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Single*

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

6. DATE OF BIRTH (MONTH, DAY, YEAR) *Oct 1887*

AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<i>Abt</i>	<i>48</i>	<i>unknown</i>		

OCCUPATION
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. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ill*

MOTHER FATHER
13. NAME *John Lacy*

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

15. MAIDEN NAME *Anna Petrasch*

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

17. INFORMANT (ADDRESS) *Joseph Lacy*

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE *7-6*

19. UNDERTAKER (ADDRESS) *H. C. Moydell*

20. FILED *11-6-1935* Registrar *J. Bredeck*

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *7-4 1935*

22. I HEREBY CERTIFY, That I attended deceased from *July 1*, 19*35*, to *July 4*, 19*35*.
I last saw *her* alive on *July 3*, 19*35*. Death is said to have occurred on the date stated above, at *5 A.* m.

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

primary septic tetanus Date of onset
Cerebral meningitis and Urinary Bladder *10 months*

Other contributory causes of importance:

myocarditis chronic 10 months

Name of operation..... Date of.....
What test confirmed diagnosis? *Physical Examination* Was there an autopsy? *Yes*

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) *W. A. Byrne*, M. D.
(Address) *1541 2120*

