

FEB 19 1940
MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1853
Do not use this space.

1. PLACE OF DEATH
 (a) County Calloway Registration District No. 104
 (b) Township Fulton Primary Registration District No. 3008 Registered No. 11
 (c) City Fulton (d) Street No. State Hospital No 1 St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred 27 yrs. 10 mos. 4 ds. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME ANNIE IRVIN
 (a) Residence, No. Marion County St. Missouri
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>7</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Single</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>-</u>				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>D.K.</u>				
7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day,hrs. ormin.
	<u>39</u>	<u>D.K.</u>	<u>D.K.</u>	
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>none</u>			
	9. Industry or business in which work was done, as 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) <u>D.K.</u>				
FATHER	13. NAME <u>D.K.</u>			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____			
	15. MAIDEN NAME <u>D.K.</u>			
MOTHER	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____			
	17. INFORMANT (ADDRESS) <u>Hospital Records State Hospital # 1</u>			
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Columbia Mo</u> DATE <u>1-15</u> 19 <u>40</u>				
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>G. D. Roberts Columbia Mo</u>				
20. FILED <u>Jan 15</u> 19 <u>40</u> <u>R. N. Cruise</u> Local Registrar.				

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan - 10 1940

22. I HEREBY CERTIFY, that I attended deceased from Feb 15 1939, to Jan 10 1940
 I last saw her alive on Jan 10 1940. Death is said to have occurred on the date stated above, at 2:30 p. m.
 The principal cause of death and related causes of importance were as follows:
Tuberculosis of joint (Rt. Knee)
Secondary infection
 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? No
 If so, specify _____
 (Signed) Walter H. Shuler, M. D.
 (Address) State Hospital # 1 Fulton Mo.

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.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

,Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.