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

Do not use this space.

38150

1. PLACE OF DEATH
County St Louis Registration District No. 1170 File No.
Township ~~Carondelet~~ Primary Registration District No. 6248 Registered No. 268
City ~~Carondelet~~ St. Louis (No.) New St Marys Hospital St. Ward)

2. FULL NAME ANNIE WALTERS.
(a) Residence. No. 6412 Etzel av St., Ward. St Louis. Mo
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 53 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): Widow
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Charles Walters
6. DATE OF BIRTH (MONTH, DAY AND YEAR): Aug 22. 1875
7. AGE: Years 53. Months 3 Days 1 If LESS than 1 day, ____ hrs. or ____ min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer
9. BIRTHPLACE (CITY OR TOWN): St Louis
(STATE OR COUNTRY): Missouri

PARENTS
10. NAME OF FATHER: Patrick Clark
11. BIRTHPLACE OF FATHER (CITY OR TOWN): Unknown
(STATE OR COUNTRY): Ireland
12. MAIDEN NAME OF MOTHER: Annie Riley
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): County Kerry
(STATE OR COUNTRY): Ireland

14. INFORMANT: Chas Walters
(Address): 6412 Etzel Av.
15. FILED 11/26. 1928 C L Jensen REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Nov. 25 1928
17. I HEREBY CERTIFY, That I attended deceased from August, 1928, to Nov. 25, 1928 that I last saw h.. alive on Nov. 24, 1928, and that death occurred, on the date stated above, at 6.30 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Embolism
478
552
193 (duration) 2 ? yrs. ? mos. ds.
CONTRIBUTORY (SECONDARY): Hemorrhage - Femoral
Vessels — (duration) yrs. mos. 3 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? Yes DATE OF 1 Yr ago?
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) Travis H Reed, M. D
, 19 (Address) 6194 Delmar Blvd

*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: Memorial Park — DATE OF BURIAL: Nov. 27 1928
20. UNDERTAKER: E E Cobb — ADDRESS: Calif

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

1. PLACE OF DEATH. St Louis
County St Louis — Registration District No. 1170 — File No.
Township
City Richmond Hts (No. , St. Ward) — Primary Registration District No. 6248 H — Registered No. 268

2. FULL NAME Annie Walters

(a) Residence. No. St., 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
F	W	Wid

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

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

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(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)

PARENTS

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT
(Address)

15. FILED 1/16, 1929 L. L. Jensen REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 20 1928

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19 , that I last saw h alive on , 19 , and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Carcinomatosis
Carcinoma of Uterus
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) Dr Aid, M. D
, 19 (Address)

*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	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

4-6

S-38150