

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

Do not use this space.

22886

**1. PLACE OF DEATH**

County.....

Registration District No.....

701

Township.....

Primary Registration District No.....

1003

City..... *St. Louis, Mo.* (No.....)

*Lamar*

File No.....

Registered No.....

6556

St.....

Ward.....

**2. FULL NAME**

*Annie Wall*

(a) Residence No. *8403 Newby* St. *13* Ward.....

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *3* yrs. *+* mos.

da. How long in U.S., if of foreign birth? yrs. mos. da.

**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 AND YEAR)**

*Unknown*

**7. AGE**

YEARS

MONTHS

DAYS

IF LESS than 1 day, ..... hrs. or ..... min.

*About 56*

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work

*House Maid*

(b) General nature of industry, business, or establishment in which employed (or employer)

*Unknown*

(c) Name of employer

**9. BIRTHPLACE (CITY OR TOWN)**

*Arcadia*

(STATE OR COUNTRY)

*Missouri*

**10. NAME OF FATHER**

*Edw. Walburn*

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY)

*Ireland*

**12. MAIDEN NAME OF MOTHER**

*Mary Weston*

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY)

*U. S. A.*

**14.**

INFORMANT (Address)

*Joseph F. Starks*  
*5300 Walnut*

**15.**

FILED.....

*11 19 1927*

*Max B. Starks*

Registrar

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** *7/18/27* 19

**17.**

I HEREBY CERTIFY, That I attended deceased from.....

*7/21/25*, 19....., to *7/17/27*, 19....., that I last saw him/her alive on *7/17/27*, 19....., and that death occurred, on the date stated above, at *7:20 a.m.*

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

*Carcinoma of uterus*

*46*

(duration) *1* yrs. *11* mos. *27* da.

**CONTRIBUTORY (SECONDARY)**

(duration) ..... yrs. .... mos. .... da.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH?.....

**0** DID AN OPERATION PRECEDE DEATH? *no* DATE OF.....

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS? *clinical*

(Signed) *Joseph F. Starks*, M. D.

*7/18/27*, 19 (Address) *5300 Walnut*

\*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**

*Calvary*

DATE OF BURIAL

*July 20 1927*

**20. UNDERTAKER**

*Aug Brockland & Co.*

ADDRESS

*1421 N. 9 St*

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.

