

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

Do not use this space.

38683

**1. PLACE OF DEATH**

County.....  
Township.....  
City..... *St. Louis* (No. *1461*)

Registration District No. *791*  
Primary Registration District No. *1003*  
*Shawmut Pl.*

File No. ....  
Registered No. *11386*  
St. .... Ward)

**2. FULL NAME**

*Anna Moulton*

(a) Residence. No. .... St., *6* 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. 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)**

*married*

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

*Frank Moulton*

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

*Union 1857*

**7. AGE**

*abt 70*

**MONTHS**

**DAYS**

IF LESS than 1 day, hrs. or min.

**8. OCCUPATION OF DECEASED**

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

*at Home*

(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)

*Texas*

**10. NAME OF FATHER**

*John Maxwell*

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

(STATE OR COUNTRY)

*Texas*

**12. MAIDEN NAME OF MOTHER**

*Unknown*

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

(STATE OR COUNTRY)

*Texas*

**14.**

**INFORMANT**

(Address)

*Frank Moulton  
1461 1/2 Shawmut Pl*

**15.**

FILED

*DEC 20 1927*

*max b starkoff*

REGISTER

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)**

*12/18 1927*

**17.**

I HEREBY CERTIFY, That I attended deceased from *June 6th 1927* to *December 18th 1927* that I last saw her alive on *December 18th 1927*, and that death occurred, on the date stated above, at *2:00* m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

*myocarditis chronic  
12/18/27  
926 1/2 9th*

(duration) *2* yrs. .... mos. .... da.

**CONTRIBUTORY (SECONDARY) DISEASE**

*Cardio-Vascular-Renal*

(duration) *3* 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? *Physical signs*

(Signed) *J. M. Brown*, M. D.  
*Dec 19, 1927* (Address) *2865 1/2 Union 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**

**DATE OF BURIAL**

*barary* *12-21 1927*

**20. UNDERTAKER**

**ADDRESS**

*Arthur J. Donnelly* *2039 Wash 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.

2967 = 21 7/20

George 2388 10-12

73 = 0907