28 1928

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

Do not use this space.

30912

1. PLACE OF DEATH
County: Knox
Township: Brewer-Benz
City: Barring T (No. ..... St. ..... Ward)

Registration District No. 439
Primary Registration District No. 4289

File No. .....
Registered No. 163

2. FULL NAME Annie McCabe

(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: 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) May-15-1855

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
73	8	21	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Milliner
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) Wheeling
(STATE OR COUNTRY) West Virginia

PARENTS
10. NAME OF FATHER Alanardo McCabe
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Ireland
12. MAIDEN NAME OF MOTHER Mary McCannon
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Ireland

14. INFORMANT .....
(Address) Mrs. Mo. Br. Hall

15. FILED Sept 10 1928 Edward Early REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 6th 1928

17. I HEREBY CERTIFY, That I attended deceased from Aug 18th, 1927, to Sept 6th, 1928, that I last saw h. alive on Sept 6th, 1928, and that death occurred, on the date stated above, at 6 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Myocarditis
(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) W. F. O'Connor, M. D.
, 19 (Address) Edina Mo.

*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: Mt Olivet Cemetery Barring Mo
DATE OF BURIAL: Sept 8 1928

20. UNDERTAKER: Kriegshauser Bros
ADDRESS: Edina, 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.