

NOV 22 1928

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

Do not use this space.

34042

1. PLACE OF DEATH

County Laclede
Township Wayfield
City Wayfield (No.) St. Ward

Registration District No. 277
Primary Registration District No. 3610

File No.
Registered No. 5- St. Ward

2. FULL NAME

Maney, Ann Davis

(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) Widow

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF E. W. Davis

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 1 1874

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

22 5 25

8. OCCUPATION OF DECEASED

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

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) near Spring Garden
(STATE OR COUNTRY) Coal Co Mo

10. NAME OF FATHER Allen S. S. S. S.

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

12. MAIDEN NAME OF MOTHER Lambert

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

14. INFORMANT W. A. Davis
(Address) Stoutland Mo

15. FILED Oct 15 1928 C. E. Carlton
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 26 1928

17. I HEREBY CERTIFY, That I attended deceased from July 28, 1928, to Oct 25, 1928, that I last saw her alive on Oct 10, 1928, and that death occurred, on the date stated above, at 5-9 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute nephritis 1183

CONTRIBUTORY Failure of Heart trouble
(SECONDARY) 10 days (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED Place Death
IF NOT AT PLACE OF DEATH, DATE OF

DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Bedside
(Signed) W. A. Davis, M. D.
Oct 27, 1928 (Address) Stoutland 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 Wore Chapel Cemetery DATE OF BURIAL Oct 28 1928

20. UNDERTAKER R. B. Lupton ADDRESS Stoutland 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.

WHILE FILLING IN THIS FORM WITH OBTAINING INFORMATION THIS IS A PERMANENT RECORD

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100-100000

DA - Belgium - 1944
Sail - 1944

100-100000
100-100000

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF BIRTH

County Laclede Registration District No. 277 File No.
Township Marion Primary Registration District No. 3610 Registered No. 3-
City (No.) St. Ward (No.)

2. FULL NAME

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

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

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 Nov 18 1918 C. E. Cantor REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 26 1918

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Nephritis
toxaemia
subacute

18. WHERE WAS DISEASE CONTRACTED (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) 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

20. UNDERTAKER ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW
 of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state H in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.
 COMPLETELY, WITH UNPAID AND UNRECORDED IS A PERMANENT RECORD

SUPPLEMENTARY

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