

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

Do not use this space.

5692

**1. PLACE OF DEATH**

County Callaway Co  
Township Patton  
City Fulton Mo (No. \_\_\_\_\_) (St. \_\_\_\_\_) (Ward \_\_\_\_\_)

Registration District No. 104  
Primary Registration District No. 3008

File No. \_\_\_\_\_  
Registered No. 55  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Anna Levey  
(a) Residence No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode)

State Hospital Mo  
(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 Widow  
(write the word)

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

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

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>about 55</u>	<u>4</u>	<u>-</u>	<u>-</u>	<u>-</u>

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Housekeeper  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) Del Mo  
(STATE OR COUNTRY)

10. NAME OF FATHER Marston Levey

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

12. MAIDEN NAME OF MOTHER Mark Peters

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

14. INFORMANT Rearda Hospital No 1  
(Address) Fulton Mo

15. FILED 2/24/29 R. N. Crews  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 24 / 19 29

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

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

Chronic Myocarditis  
93  
84  
(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY None beyond the above  
(SECONDARY) needed after  
(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18. WHERE WAS DISEASE CONTRACTED Del Mo  
IF NOT AT PLACE OF DEATH? \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? No DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? No  
WHAT TEST CONFIRMED DIAGNOSIS? General Laboratory  
(Signed) R. N. Crews, M. D.  
, 19 \_\_\_\_\_ (Address) State Hospital No 1

\*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 Gravels Mo DATE OF BURIAL 2-26 1929

20. UNDERTAKER Mahair and Son ADDRESS Gravels 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.

21 1929  
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34  
1  
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