

SEP 24 1930

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

Do not use this space.

22667

1. PLACE OF DEATH
County Howard, Registration District No. 878
Township..... Primary Registration District No. 4222
City Fayette, (No.) St. (Ward)

File No.
Registered No. 42

2. FULL NAME Sally Anderson,
(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 Black 5. SINGLE, MARRIED, WIDOWED OR DIVORCED widowed, (write the word)

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hra. ormin.
about 45 45 #

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) Missouri
(STATE OR COUNTRY)

10. NAME OF FATHER David Gaw.

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

12. MAIDEN NAME OF MOTHER Louise Parks,

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

14. INFORMANT Edna Gates,
(Address) St Louis, Mo.

15. FILED 8/30/30 V. O. Bonham
REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7 26 30 1929

17. 26 HEREBY CERTIFY, That I attended deceased from July 1929 to July 26, 1929 that I last saw her alive on July 26, 1929, and that death occurred, on the date stated above, at 8 p m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Hemorrhage
131
82A

(duration) yrs. mos. ds.
CONTRIBUTORY Ch. Nephritis
(SECONDARY) (duration) 1 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED L
IF NOT AT PLACE OF DEATH.....
DID AN OPERATION PRECEDE DEATH? no DATE OF.....
WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS? none
(Signed) W. Bloom M. D.
19 (Address) Fayette 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 City Cometary 7 29 30 DATE OF BURIAL 1930

20. UNDERTAKER City T. Halley, Fayette, Mo. ADDRESS

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.

