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

Do not use this space.

24793

File No. 6952

Registered No. 791

Registration District No. 1003

Primary Registration District No.

1. PLACE OF DEATH

County

Township

City (No. 2516 N. 16th St. Ward)

2. FULL NAME Mrs Anna Ross

(a) Residence. No. 2516 N 16th St. St. 26 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	White	Married

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

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

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
Aber 69	unknown		

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

9. BIRTHPLACE (CITY OR TOWN) Bonne Terre
(STATE OR COUNTRY) St Francois Co Mo

PARENTS

10. NAME OF FATHER J. Brunk

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Bonne Terre
(STATE OR COUNTRY) St Francois Co

12. MAIDEN NAME OF MOTHER Unknown Brunk

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Bonne Terre
(STATE OR COUNTRY) St Francois Co

14. INFORMANT C. J. Russell
(Address) Bonne Terre Mo

15. FILED JUL 14 1930 Wm C Stokes REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7/14 1930

17. No Physician in attendance
I HEREBY CERTIFY, That I attended deceased from ....., 19...., to ....., 19.....
that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at 10.50 A.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

93C 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? No

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) J. W. Kenner ~~M.D.~~

7/15 1930 (Address) Desloge

*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
Bonne Terre Mo	7-15 1930
20. UNDERTAKER	**ADDRESS**
Ward Bros	Bonne Terre Mo

N. B.—Every item of information should be carefully supplied. Blanks should be filled in. Physicians should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.