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

Do not use this space.

25446

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 10[illegible]

City St. Louis (No. Jewish Hospital St. ..... Ward)

File No. .....

Registered No. 7685

2. FULL NAME Anna Wittig

(a) Residence. No. 921 So. Sarah 18 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	Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan. 28 - 1869

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
61	6	[illegible]	

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

9. BIRTHPLACE (CITY OR TOWN) Jefferson Co.
(STATE OR COUNTRY) Mo.

PARENTS

10. NAME OF FATHER Wesley Jones

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

12. MAIDEN NAME OF MOTHER Margaret Drunner

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

14. INFORMANT L. M. Jones
(Address) 921 So. Sarah

15. FILED ....., 19 [illegible] REGISTRAR

MEDICAL CERTIFICATE OF DEATH 3

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7/28/30 19

17. I HEREBY CERTIFY, That I attended deceased from 3/22/30, 19..., to 7/28/30, 19..., that I last saw her alive on 7/28/30, 19..., and that death occurred, on the date stated above, at 12 00 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Carcinoma of Cervix and uterus

48
133A
123B

(duration) ? yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Bilateral pyonephrosis

(duration) ? yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH Colostomy

DID AN OPERATION PRECEDE DEATH? Yes DATE OF .....

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? Autopsy

(Signed) O. Eckert, M. D.

, 19 (Address) Jewish Hospital

*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 Bellefontaine Cemetery | DATE OF BURIAL Aug. 1st 1930

20. UNDERTAKER Peetz Bros. | ADDRESS 3029 Lafayette

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.