

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

791
1003

16891
Do not use this space.

REC'D JUN 12 1939

1. PLACE OF DEATH

(a) County..... Registration District No.....
 (b) Township..... Primary Registration District No..... Registered No. **4425**
 or *St. Louis* (d) Street No. *Mo. Baptist Hosp.* St.
 City..... (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
46 3

2. PRINT FULL NAME *ANNICE A. WILLARD OFALLON, ILL.*

(a) Residence, No. St. *WA* (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *F* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *MARRIED*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *WILLIAM G. WILLARD*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *FEB. 20, 1882*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day,hrs. ormin.
	<i>54</i>	<i>7</i>	<i>22</i>	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *H' WIFE*

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *OFALLON ILL*

FATHER

13. NAME *JOSEPH CORBRIDGE*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *YORKSHIRE ENGLAND*

MOTHER

15. MAIDEN NAME *FANNIE TINKER*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *YORKSHIRE ENGLAND*

17. INFORMANT (ADDRESS) *WILLIAM G. WILLARD OFALLON ILL.*

18. BURIAL, CREMATION, OR REMOVAL PLACE *LEBAXON ILL* DATE *5-15* 19*39*

19. FUNERAL DIRECTOR (NAME) (ADDRESS) *A. H. HOPPE INC. 4700 Washington*

20. FILED *MAY 13 1939* *J. F. Budick* Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *MAY 12 1939*

22. I HEREBY CERTIFY, That I attended deceased from *October 1924* to *May 12 1939*

I last saw her alive on *May 12 1939* Death is said to have occurred on the date stated above, at *10:12 P* m.

The principal cause of death and related causes of importance were as follows:

Meningitis - Type S Pneum - m. cerebri Date of onset *5-10-39*

Other contributory causes of importance: *Left status median* *5-7-39*

Name of operation *none* Date of

What test confirmed diagnosis? *Serology* Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? *←* Date of injury, 19.....

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) *E. B. Waters* M. D.

(Address) *Ridgwood, Mo.*

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

1 X 16405

AA25

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed

Albert G. Hoyle

Licensed Embalmer No. 2971

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.