

Registration District No. **213**

Primary Registration District No. **3014**

Registrar's No. **28**

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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Cole
(b) City or town Jefferson City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St Mary's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 weeks
(Specify whether
In this community _____
years, months or days)

8. (a) PRINT FULL NAME Mary Genevieve Anthony
3. (b) If veteran, name war ✓ 5. (c) Social Security No. ✓

4. Sex F 5. Color or race Cole 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Oct 4 1910
(Month) (Day) (Year)

8. AGE: Years 30 Months 2 Days 24 If less than one day _____ hr. _____ min.

9. Birthplace St Aubert Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Housekeeper

11. Industry or business _____

FATHER { 12. Name John Anthony
13. Birthplace St Aubert Mo
(City, town, or county) (State or foreign country)
MOTHER { 14. Maiden name Lena Pearl
15. Birthplace St Aubert Mo
(City, town, or county) (State or foreign country)

18. (a) Informant John Anthony Jr.

(b) Address Chamisso 1 - Mo

17. (a) Burial (b) Date thereof 1-30-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Chamisso Mo

18. (a) Signature of funeral director Mostow Funeral Home
(b) Address Linn Mo

19. (a) 1-30-41 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Osage
(c) City or town Chamisso
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location) 1
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 28
year 1941 hour 3:30 minute P
21. I hereby certify that I attended the deceased from Jan 2nd
1941 to Jan 28th 1941
that I last saw her alive on Jan 28th 1941
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia
Duration _____

Due to _____
Due to _____

Other conditions Aplastic Anemia
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: _____
Of operations _____
If autopsy Pneumonia, Amyloid degeneration of all organs.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) ✓
(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
(a) Means of injury _____

23. Signature Thomas Kelly MD (M. D. or other) D
Address Jefferson City Mo Date signed Jan 30, 41

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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 Vernon M. Morton

Licensed Embalmer No. 4125

P. O. Address Lenox

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 2309

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 213

Primary Registration District No. 3014

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Cole
(b) City or town Jefferson City
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community _____
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME

Mary Genevieve Anthony

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 28
year 1941 hour _____ minute _____ M.

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____,
and that death occurred on the date and hour stated above.

4. Sex 7 5. Color or race l
6. (a) Single, widowed, married, divorced single

Immediate cause of death Pneumonia Bronch

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased: (Month) (Day) (Year)

Due to _____

8. AGE: Years 30 Months 2 Days 24 If less than one year _____ hr. _____ min.

Due to _____

9. Birthplace: (City, town, or county) (State or foreign country)

Other conditions: Anemia
(Include pregnancy within 3 months of death)

10. Usual occupation _____

Major findings: Of operations _____

11. Industry or business _____

Of autopsy _____

12. Name _____

13. Birthplace: (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace: (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof: (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 1-30-41 (b) D. Beesoms
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? (Specify type of place) (e) Means of injury _____

23. Signature Thos J. Kelly (M. D. or other) MD

Address Jeff. City Date signed 1/30/41

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

