

STATE OF OHIO
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH
County Montgomery Registration District No. 907 File No. 40938
Township Jefferson Primary Registration District No. 5377 Registered No. 92
or Village No. _____ St., _____ Ward _____
(If death occurred in a hospital or institution, give its NAME instead of street and number)
or City of _____

2 FULL NAME Anna Smith Booth
(a) Residence No. Dayton R 710 # 11 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 Male 4 COLOR OR RACE White 5 Single, Married, Widowed or Divorced (write the word) Married
5a If married, widowed or divorced HUSBAND of (or) WIFE of _____

6 DATE OF BIRTH (month, day, and year) Sep 14 - 1853

7 AGE Years Months Days If LESS than 1 day _____ hrs. or _____ min.
67 9 17

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

9 BIRTHPLACE (city or town) Ohio
(State or country)

10 NAME OF FATHER Geo. Booth

11 BIRTHPLACE OF FATHER (city or town) _____
(State or country) Penn

12 MAIDEN NAME OF MOTHER Ellen Ferguson

13 BIRTHPLACE OF MOTHER (city or town) _____
(State or country) Ireland

14 Informant W. Booth
(Address) Dayton O

15 Filed July 2 1921 Chas. Ramsey
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

15 DATE OF DEATH (month, day and year) July 1 1921
17 I HEREBY CERTIFY, That I attended deceased from June 23 1921 to July 1 1921, that I last saw him alive on July 1 1921, and that death occurred, on the date stated above, at 9:30 P.M.
The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy
(duration) 4 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? No Date of _____

Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) W. W. Conroy, M. D.
July 2 1921 (Address) W. Conroy, M. D.

*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. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Woodland Cem. DATE OF BURIAL July 5 1921

20 UNDERTAKER (License No. 70564) ADDRESS W. Booth

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. 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. See instructions on back of certificate.