

PLACE OF DEATH

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

County _____

Township _____

or _____

Village _____

City _____

Registration District No. _____

File No. **32091**Primary Registration District No. **1003**Registered No. **7696**(NO. **3855 Evans**)St. **1st** Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME **Sophia Kelleher**

PERSONAL AND STATISTICAL PARTICULARS

SEX **Female** COLOR OR RACE **White** SINGLE MARRIED WIDOWED OR DIVORCED **Married**
(Write the word)DATE OF BIRTH _____
(Month) (Day) (Year)AGE **56** yrs. mos. ds. IF LESS than 1 day, ___ hrs. or ___ min.?OCCUPATION (a) Trade, profession, or particular kind of work **Housewife**
(b) General nature of industry, business, or establishment in which employed (or employer)BIRTHPLACE (City or town, State or foreign country) **England**PARENTS NAME OF FATHER **David Green**BIRTHPLACE OF FATHER (City or town, State or foreign country) **England**MAIDEN NAME OF MOTHER **Jane Green**BIRTHPLACE OF MOTHER (City or town, State or foreign country) **England**

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Coon Kelleher**(ADDRESS) **3856 Evans**Filed **1910** **W. Wheeler Bond** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH **Oct 2, 1910**
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from **July 1, 1910**, to **Oct 2, 1910**, that I last saw her alive on **Sept 29, 1910**, and that death occurred, on the date stated above, at **12:30 p.m.**

The CAUSE OF DEATH* was as follows:

Gastric Ulcer
1177
10313

(Duration) ___ yrs. ___ mos. ___ ds.

Contributory **Hemorrhage**
(SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.(Signed) **J. A. Caluane** M. D.
Oct 2, 1910 (Address) **1310 N. Grand St.**

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death?

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL **Calvary** DATE OF BURIAL **Oct 4, 1910**UNDERTAKER **Joe Quinn** ADDRESS **2126 Cass**

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Standard Certificate

Whooping cough; Chronic valvular interstitial nephritis, etc. The (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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—Name, first, the affection with reg always the same

