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.

Copy of Original

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

PLACE OF DEATH

County St. Louis

Township

or

Village

or

City University City (NO. 6500 Olive St. St.: Ward)

Registration District No. 1160 File No. 17632

Primary Registration District No. 4470 Registered No. 15

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

FULL NAME Martin Walsh

PERSONAL AND STATISTICAL PARTICULARS

SEX Male

COLOR OR RACE White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Married

DATE OF BIRTH Nov. (Month) 9th (Day), 1889 (Year)

AGE 23 yrs. 5 mos. 24 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work Saloon Keeper

(b) General nature of industry, business, or establishment in which employed (or employer) Bartender

BIRTHPLACE (City or town, State or foreign country) Missouri

PARENTS

NAME OF FATHER James Walsh

BIRTHPLACE OF FATHER (City or town, State or foreign country) Ireland

MAIDEN NAME OF MOTHER Annie Byrne

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ireland

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. Beatrice Walsh

(ADDRESS) 6296a Bartmer ave

Filed May 4, 1913. R. A. Phelan REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH May (Month) 3rd (Day), 1913 (Year)

I HEREBY CERTIFY, that I attended deceased from Mar 12, 1913, to May 3, 1913, that I last saw him alive on May 3, 1913, and that death occurred, on the date stated above, at 9:30 p.m.

The CAUSE OF DEATH* was as follows:

Diabetis Mellitus

59

Same as above (Duration) ___ yrs. ___ mos. ___ ds.

Contributory (SECONDARY) Unknown (Duration) ___ yrs. ___ mos. ___ ds.

(Signed) R. A. Phelan M. D.

May 4, 1913 (Address) 6531 Bartmer

*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 Cemetary

DATE OF BURIAL 5/6, 1913

UNDERTAKER Arthur Donnelly

ADDRESS 2039 Wash St

PLACE OF DEATH

County _____

Township _____ Registration District
or
Village _____ Primary Registration
or
City _____ (NO. _____, _____

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH _____, 1_____
(Month) (Day) (Year)

AGE _____ yrs. _____ mos. _____ ds. | If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country) _____

PARENTS

NAME OF FATHER _____

BIRTHPLACE OF FATHER (City or town, State or foreign country) _____

MAIDEN NAME OF MOTHER _____

BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191____, _____
REGISTRAR

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

_____ File No. _____

_____ Registered No. _____

_____ St.; _____ Ward)

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

MEDICAL CERTIFICATE OF DEATH

ATH

_____, 191____
(Month) (Day) (Year)

HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____,

aw h_____ alive on _____, 191____,

eath occurred, on the date stated above, at _____ m.

E OF DEATH* was as follows:

_____

_____

_____

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory _____
(Secondary)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

_____, 191____ (Address) _____

*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	DATE OF BURIAL
	_____, 191____
UNDERTAKER	ADDRESS

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

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