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.

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

1 PLACE OF DEATH

County .....

Township ..... Registration District No. 791 File No. 27587

or

Village ..... Primary Registration District No. 1008 Registered No. 8281

or

City S Louis (NO. City Hospital St. 1 Ward)

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

2 FULL NAME Michael McGinley

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Single

6 DATE OF BIRTH June (Month) 12 (Day) 1876 (Year)

7 AGE 42 yrs. 2 mos. 18 ds. If LESS than 1 day, ....hrs. or ....min.?

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

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

9 BIRTHPLACE (City or town, State or foreign country) S Louis

PARENTS

10 NAME OF FATHER Charles McGinley

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

12 MAIDEN NAME OF MOTHER Susan Rush

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hospital Information E Roman

(Address) City Hospital

15 Filed SEP - 1 1918 Max C Starkloff Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug (Month) 30 (Day) 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Aug 13, 1918, to Aug 30, 1918, that I last saw him alive on Aug 30, 1918, and that death occurred, on the date stated above, at 6 05 P.M.

The CAUSE OF DEATH* was as follows:

Chronic valvular disease

Mitral regurgitation

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

CONTRIBUTORY (Secondary) Broncho-pneumonia

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

(Signed) Emil C Hein M. D.

Aug 30, 1918 (Address) City Hospital

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

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. 17 ds. In the State 42 yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death?

Former or usual residence 2013 Bissel

19 PLACE OF BURIAL OR REMOVAL Calvary

DATE OF BURIAL Sep 2, 1918

20 UNDERTAKER G H Bockers

ADDRESS 4320 Warne ave

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

**1 PLACE OF DEATH**

County .....

Township..... Registration District No..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City..... (NO....., .....St.;.....Ward)

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

**2 FULL NAME** .....

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.

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

## PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word) |
|---|---|---|
| | | |

**6 DATE OF BIRTH**

....., 1..... (Month) (Day) (Year)

**7 AGE** .....yrs.....mos.....ds.

If LESS than 1 day,.....hrs. or.....min.?

**8 OCCUPATION**
(a) Trade, profession, or particular kind of work.....

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

**9 BIRTHPLACE**
(City or town, State or foreign country)

PARENTS

**10 NAME OF FATHER**

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

**12 MAIDEN NAME OF MOTHER**

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

**14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) .....

(Address).....

**15** .....

Filed....., 191....., .....
Registrar

## MEDICAL CERTIFICATE OF DEATH

**16 DATE OF DEATH**

....., 191..... (Month) (Day) (Year)

**17** I HEREBY CERTIFY, that I attended deceased from

....., 191....., to....., 191.....

that I last saw h.....alive on....., 191.....,

and that death occurred, on the date stated above, at.....m.

The CAUSE 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.

**18 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.....

| 19 PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ....., 191..... |
|---|---|
| 20 UNDERTAKER | ADDRESS |