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. 701 File No. 30550
or
Village ..... Primary Registration District No. 1008 Registered No. 8424
or
City St Louis Mo (NO. 6240 Clemente ave St. 28 Ward)

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

2 FULL NAME Mary Rigan

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Sept 1 (Month) (Day) 1872 (Year)

7 AGE: 46 yrs. mos. 5 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE (City or town, State or foreign country): Ireland

PARENTS
10 NAME OF FATHER: John Condon
11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Ireland
12 MAIDEN NAME OF MOTHER: Ellen Going
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Daniel Rigan
(Address) 6240 Clemente Ave.

15 Filed ..... 191 Max C Starkoff Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept. (Month) 5th (Day) 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from June 23rd 1918, to Sept 5th 1918, that I last saw her alive on Sept 4th 1918, and that death occurred, on the date stated above, at 12:30 p.m.

The CAUSE OF DEATH* was as follows:
Nephritis Chronic
(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Valvular Disease of Heart
(Duration) 3 yrs. mos. ds.

(Signed) J. Theodore Gill M. D.
9/5th 1918 (Address) 6336 Delmar

*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: Calvary Cem
DATE OF BURIAL: Sept 7 1918

20 UNDERTAKER: Katz Bros
ADDRESS: 2739 Lafayette 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 .....

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

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

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