LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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. 35906

or

Village ..... Primary Registration District No. 1003 Registered No 9247

or

City St Louis (No. St Marys Infirmary St. 7 Ward)

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

2 FULL NAME John J McGinn

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 Sept 29th (Month) (Day) 1875 (Year)

7 AGE 43 yrs. 7 mos. ds. If LESS than 1 day, ...hrs. or ....min.?

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

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

12 MAIDEN NAME OF MOTHER Unknown

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Rev F Scott
(Address) Rock Church

15 Filed OCT 7 1918 1918 Mary C Starkloff Registrar

MEDICAL CERTIFICATE OF DEATH

2

16 DATE OF DEATH Oct (Month) 6 (Day) 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Oct 4, 1918, to Oct 6, 1918, that I last saw him alive on Oct 6, 1918, and that death occurred, on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia
108
131

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

CONTRIBUTORY (Secondary) Chronic Interst Nephritis

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

(Signed) F Neuhoff M. D.

Oct 6, 1918 (Address) 3206 Lafayette

*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. 4 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted if not at place of death? .....

Former or usual residence Rock Church Grand & Cook

19 PLACE OF BURIAL OR REMOVAL Kirkwood Mo

DATE OF BURIAL Oct 8, 1918

20 UNDERTAKER J J Quinn

ADDRESS 3126 Carr

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

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

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