LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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. 36232

or

Village ..... Primary Registration District No. 1003 Registered No. 9602

or

City St. Louis (NO. 3138 Hickory St.; 16 Ward)

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

2 FULL NAME Alice McDermott

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 Apr. (Month) 10th (Day), 1893 (Year)

7 AGE 25 yrs. 6 mos. 4 ds.

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

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

9 BIRTHPLACE (City or town, State or foreign country) Joliet Ills.

PARENTS

10 NAME OF FATHER Michael Kane

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

12 MAIDEN NAME OF MOTHER Bridget McCarthy

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Michael Kane
(Address) 3138 Rutgers St

15 Filed OCT 15 1918, 191 Max C. Stackloff Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct. (Month) 14 (Day), 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Oct 8, 1918, to Oct 14, 1918, that I last saw her alive on Oct 14, 1918, and that death occurred, on the date stated above, at 10:20 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

113
108 10

(Duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Influenza

(Duration) ..... yrs. ..... mos. 12 ds.

(Signed) Stephen Vizeau M. D.

Oct 14, 1918 (Address) 3202 Park

*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 Cemetery

DATE OF BURIAL Oct. 16, 1918

20 UNDERTAKER Cullinane Bros.

ADDRESS 1710 N Grand a

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 .....

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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