

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

24728

1. PLACE OF DEATH

County..... Registration District No..... File No.....
 Township..... Primary Registration District No..... Registered No. **7521**
 City St Louis (No. 2583 Warren) St. Ward.....

2. FULL NAME

Virginia Hickey
 (a) Residence. No..... St. 18 Ward.....
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 25th 1902

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
18 11 25

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Shoe worker
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) St Louis
 (STATE OR COUNTRY)

10. NAME OF FATHER Patrick Hickey

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Mich
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Amanda Bayer

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) St Louis
 (STATE OR COUNTRY)

14. INFORMANT Margaret Hickey
 (Address) 2583 Warren St

15. FILED SLIP 1-1321 May 6 Starkeoff
 FILED 1919

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 30 19 21

17. I HEREBY CERTIFY That I attended deceased from Sept 18 19 21
 that I last saw him alive on Sept 29 19 21 and that death occurred, on the date stated above, at 10:10 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Valvular
23A (duration) yrs. ? mos. da.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. da.

18. WHERE DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH:

8 DID AN OPERATION PRECEDE DEATH? DATE OF.....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Roentgen
 (Signed) Arthur J. Donnelly M. D.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Calvary DATE OF BURIAL 9-23 1921

20. UNDERTAKER Arthur J. Donnelly ADDRESS 2039 Market

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.

