

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

30157

1. PLACE OF DEATH

County.....

Registration District No.....

Township.....

Primary Registration District No.....

City.....

St. Louis

(No.)

In Ambulance

File No.....

9713

Registered No.....

St.....

Word)

2. FULL NAME

(a) Residence No.....

(Usual place of abode)

Mary Davis

976 Mound

St.,

3

Ward.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U.S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS**3. SEX****4. COLOR OR RACE****5. SINGLE, MARRIED, WIDOWED OR DIVORCED** (write the word)

Female

White

Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF**6. DATE OF BIRTH (MONTH, DAY AND YEAR)**

April 5 1860

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

64

6

~~28~~**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work

Bake Shop

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

F Amos Bars

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

St. Louis

Mo.

10. NAME OF FATHER

Not Known

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

Not Known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

PARENTS**14. INFORMANT**

(Address)

John J. Brown

F Amos Bars

15. FILED

19

Mar 6 Starceff

REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH**16. DATE OF DEATH (MONTH, DAY AND YEAR)**

10/27 1924

17.

I HEREBY CERTIFY, That I attended deceased from.....

....., 19....., to....., 19....., that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at..... 5-15 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis

N.M.C.

CONTRIBUTORY (SECONDARY)**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?.....

DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed).....

10/26 1924 (Address)

Deputy Coroner

*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**DATE OF BURIAL**

Galway

Oct 27 1924

20. UNDERTAKER**ADDRESS**

Key Luome & Co.

N Market

Revised United States Standard Certificate of Death

(Approved by U. S. Census and American Public Health Association.)

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill, (a) Salesman, (b) Grocery, (a) Foreman, (b) Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework* or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report

"Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of———(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasm); *Measles, Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*), may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

Dr. James Stewart,
Jefferson City, Mo.

Dear Doctor:

The supplemental death certificate of Mary Scolley O'Neill who died October 23rd, 1924, was dis-interred by permission of this department for identification.

According to history this woman was employed by Famous & Barr and was living under the assumed name of Mary Davis, being estranged from her relatives, whom upon making search for her learned from some friends that she had been buried by the Welfare Association of Famous & Barr, and to make sure such was the case, asked permission from this office for the dis-interment, to enable them to see if such was really the case.

The affidavit accompanying the Supplemental I felt would be sufficient proof to your department, to cover the correction.

Yours respectfully,

Leon Grosch

Deputy Registrar

JAN - 6 Rec'd 2 PM

49-3015
b2b1

The undersigned were present
at Calvary Cemetery, St. Louis, Mo
on Dec 23, 1925 when the body
buried as Mary Davis was disinterred
and positively identify her as Mrs
Mary Scally O'Neill daughter of the
late Robert & Mary Pound Scally and
sister of Robert-Edward and the late
Mrs Scally.

Signed

Mrs Helene B. Heaghen.

R.M. Scally

Mrs. Mary F. Scally

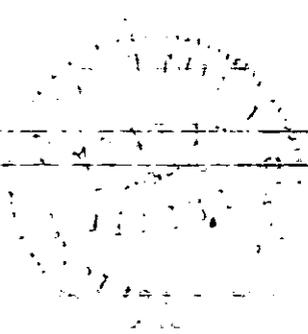
Sworn to before me this 30 day of Dec
1925

Albert H. Harper

Notary Public
My Comm. Exp. Oct 26-27

S(3) 30157

1924



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

30157

1. PLACE OF DEATH.

County..... Registration District No. 701 File No.
 Township..... Primary Registration District No. 1003 Registered No. 9713
 City..... (No.) St. Ward)

2. FULL NAME Mary Scully O'Neil

(a) Residence. No. St. 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) Widow
 5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) not known
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. abt 60
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Booker
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer Famous Balm

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Irishland
 10. NAME OF FATHER Robert Scully
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Irishland
 12. MAIDEN NAME OF MOTHER Mary Powell
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Irishland

14. INFORMANT (Address) Robert Scully 4000 Humphreys St
 15. FILED DEC 30 1927 Max C Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-23 1927
 17. I HEREBY CERTIFY That I attended deceased from 19..... to 19..... (that I last saw him alive on 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. da.
 18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH.....
 DID AN OPERATION PRECEDE DEATH..... DATE OF.....
 WAS THERE AN AUTOPSY.....
 WHAT TEST CONFIRMED DIAGNOSIS.....
 (Signed)....., M. D.
 , 19 (Address)

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19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL
Calvary Cem 19
 20. UNDERTAKER ADDRESS
Henry Lentner 1517 Market

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE

TEMPORARY

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