

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

1. PLACE OF DEATH

County.....

Registration District No. 791

Township.....

Primary Registration District No. 1003

City *St. Louis* (No. *1397 Union*)

File No. 38493

Registered No. 12224

2. FULL NAME *Michael Hattery*

(a) Residence, No. *1397 Union* St., *98* Ward.

(Usual place of abode) (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 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) *Unknown*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. *About 85*

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ireland*

10. NAME OF FATHER *Michael Hattery*

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

12. MAIDEN NAME OF MOTHER *Winford Cannon*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *Ireland*

14. INFORMANT *James Corrigan*  
(Address) *1397 Union*

15. FILED *DEC 30 1925* REGISTERED *May B. Starkeoff*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *12/29* 19*25*

17. I HEREBY CERTIFY That I attended deceased from *Nov. 25* to *Dec 30*, 19*25* that I last saw him alive on *Dec 28*, 19*25*, and that death occurred, on the date stated above, at *9:45 P.* m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

*Broken compensation of heart arteriosclerosis* (duration) yrs. *1 1/2* mos. ds.

CONTRIBUTORY *Smoking* (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH. *POA*

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) *Th. Nelson* M. D. *Dec 30 1925* (Address) *1483 Union Blvd*

\*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 *12/31* 19*25*

20. UNDERTAKER *Pullin-Kelly* ADDRESS *4527 Easton*

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.

