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

Do not use this space.

✓ 40350

File No. .....

Registered No. 12397

1. PLACE OF DEATH

County ..... Registration District No. .....

Township ..... Primary Registration District No. 1003

City St. Louis City Hospital ..... St. ..... Ward)

2. FULL NAME 11577 Matthew W Fox

(a) Residence. No. 111 S 7 St., 22 Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

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) July 26 - 1867

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
59	5	3	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Paperhanger.

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

(c) Name of employer

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

PARENTS

10. NAME OF FATHER: Michael Fox

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

12. MAIDEN NAME OF MOTHER: Margaret Mahoney

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

14. INFORMANT: Hospital Informant

(Address) E Rowan City Hospital

15. FILED ..... 19 ..... Max C Starkcoff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 29 1926

17. I HEREBY CERTIFY, That I attended deceased from Dec 6, 1926, to Dec 29, 1926, that I last saw him alive on Dec 29, 1926, and that death occurred, on the date stated above, at 9 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Pulmonary Tuberculosis

23A (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 31 (duration) ..... yrs. ..... mos. ..... ds.

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

DID AN OPERATION PRECEDE DEATH? No DATE OF .....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) Reuben M. Smith M.D.

12/29, 1926 (Address) City Hospital

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Calvary

DATE OF BURIAL: 12-31-1926

20. UNDERTAKER: John P. Collins, 1039 N Grand

ADDRESS

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.

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