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

Do not use this space.

9787

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. .....

Township ..... Primary Registration District No. 1003 Registered No. 23217

City St Louis (No. 4348 Page Blvd ..... St. ..... Ward)

2. FULL NAME Alexander M. McAuliff

(a) Residence. No. 4348 Page Blvd 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. ..... 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)
Male	White	Married

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Maude McAuliff

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 1 - 1856

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70	10	6	

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) Gov't Clerk
(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) St Louis
(STATE OR COUNTY) Mo

PARENTS

10. NAME OF FATHER J D McAuliff
11. BIRTHPLACE OF FATHER (CITY OR TOWN) U.S.
(STATE OR COUNTY)
12. MAIDEN NAME OF MOTHER Emeline Bostwick
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) U.S.
(STATE OR COUNTY)

14. INFORMANT Wm. McAuliff
(Address) 4348 Page Blvd

15. FILED MAR -9 1927 Mary C Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 7 1927

17. I HEREBY CERTIFY, That I attended deceased from Nov 15, 1926, to March 7, 1927 that I last saw him alive on March 1 1927, and that death occurred, on the date stated above, at 11:45 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

(1) Aneurysm of aorta

(duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....

(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? X-ray
(Signed) Anthony B. Day, M. D
3-8-, 1927 (Address) 910 University Club Bldg.

*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, CREATION, OR REMOVAL Bellefontaine Cem — DATE OF BURIAL Mch 9 1927

20. UNDERTAKER Aron Lucas — ADDRESS 2707 N Grand

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD