

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

Do not use this space.

9961

1. PLACE OF DEATH

County..... Registration District No. 791
Township..... Primary Registration District No. 1003
City..... (No. 5659 Vernon Ave) St. Ward)

File No.
Registered No. 2536
St. Ward)

2. FULL NAME Helen Walsh

(a) Residence. No. 5659 Vernon Ave St. 5 Ward. (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. 5-1884

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.
42 6 8 153B

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. Stenographer
(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) Kentucky

10. NAME OF FATHER John Walsh

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

12. MAIDEN NAME OF MOTHER Margaret Walsh

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

14. INFORMANT (Address) May Walsh
5659 Vernon Ave

15. FILED 11-21-21 Marie Starceff Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 13 1927

17. I HEREBY CERTIFY That I attended deceased from Jan 1 1927 (to Mar 12 1927) that I last saw him alive on Mar 12 1927 and that death occurred, on the date stated above, at 2 1/2 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Septicemia Prescop
153B
4154B
(duration) 10 yrs. mos. da.

CONTRIBUTORY (SECONDARY) Infectious multiple
follicular pressure sores
(duration) yrs. mos. da.
Infection from bed sore

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

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

20. WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Usual
(Signed) D. Chownmiller, M. D.
May 4, 1927 (Address) 1035 Mission 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, CREMATION, OR REMOVAL Covington Ky DATE OF BURIAL 3/15 1927

20. UNDERTAKER Southern ADDRESS 7515
8 Brady

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.

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Mr. [unclear] [unclear]