

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

Do not use this space.

12862

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City..... (No. **4706 Minnesota Ave.**) St. Ward.....
 Registered No. **3238**

2. FULL NAME Joseph Brady

(a) Residence No. **4706 Minnesota Ave.** St. **15** 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 **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) **June 6 1925**

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	1	9	26	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **None**
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

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

10. NAME OF FATHER **John Brady**

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

12. MAIDEN NAME OF MOTHER **Winifred Conlon**

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

14. INFORMANT **John Brady**
 (Address) **4706 Minnesota Ave**

15. FILED **APR -1 1927** **Max G. Starckoff**
 Registrar

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Apr 2 - 19 27**

17. I HEREBY CERTIFY, That I attended deceased from **March 28**, 19**27**, to **April 2**, 19**27**, that I last saw him alive on **April 1**, 19**27**, and that death occurred, on the date stated above, at **8 A.** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Catastrophic Drowning
1272
6913 (duration) yrs. mos. **6** ds.
 CONTRIBUTORY **Autism** (SECONDARY) (duration) yrs. mos. **3** ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

8 DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) **John W. Brady**, M. D.
Apr 1, 19**27** (Address) **1467 Lincoln Ave**

*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 **Mount Olive** DATE OF BURIAL **4-4-1927**

20. UNDERTAKER **Southern** ADDRESS **7315 S. Broadway**

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain language so that it may be properly classified. Exact statement of OCCUPATION is very important.

Mr. Brady -

1467 Union Ave

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County.....

Township.....

City *St. Louis* (No.)

Registration District No. *791*

Primary Registration District No. *1003*

File No.

Registered No. *3238*

St. Ward)

2. FULL NAME

(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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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m

4. COLOR OR RACE

w

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

S

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

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If LESS than 1 day, hrs. or min.

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

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9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

14.

INFORMANT

(Address)

15.

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FILED, 19

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Apr 27 19*

17.

I HEREBY CERTIFY That I attended deceased from 19

that I last saw him alive on 19, and that death occurred, on the date stated above, at

THE CAUSE OF DEATH WAS AS FOLLOWS:

Accidental - Suicide

Acidosis from Diabetic Information given over Phone by Dr. J. W. Brady 6-28-27 Rev. of N. S.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH:

DID AN OPERATION PRECEDE DEATH?

WAS THERE AN AUTOPSY? *69 B*

WHAT TEST CONFIRMED DIAGNOSIS

(Signed)

, 19 (Address)

*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

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

N. B.—Every item mentioned herein 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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

5-12962