

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

Do not use this space.
13488
✓

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City **St. Louis** (No. **City Hospital**)..... St. Ward

File No.
Registered No. **3821**

2. FULL NAME

Lawrence Quinn
(a) Residence. No. **711 218** St., **25** Ward. (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

MEDICAL CERTIFICATE OF DEATH

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Widower**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **4/19 1927**

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

17. I HEREBY CERTIFY, That I attended deceased from, 19....., to, 19..... that I last saw h..... alive on..... 19....., and that death occurred, on the date stated above, at..... **8-00 P**..... m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **July 17-1868**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
58 | 9 | 9

92A
Cerebral Apoplexy
of Hemorrhagic
Character
(duration)..... yrs. mos. ds.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work **Plumber**
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

CONTRIBUTORY (SECONDARY) **7401**

9. BIRTHPLACE (CITY OR TOWN) **Wash. Mo** (STATE OR COUNTRY)

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

10. NAME OF FATHER **Wm Quinn**

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

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

19. WAS THERE AN AUTOPSY? **Yes**

12. MAIDEN NAME OF MOTHER **Johnna Mahoney**

WHAT TEST CONFIRMED DIAGNOSIS.....

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

(Signed) **H. W. Falk** M. D.

14. INFORMANT **Wm Roberts** (Address) **4842 Nall Bridge**

4/21, 1927 (Address) **Deputy Coroner**

*State the DISEASE CAUSING DEATH, or if deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

15. FILED **21 1927** **Maule Starkleaf** REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **Memorial Park** DATE OF BURIAL **4/21 1927**

20. UNDERTAKER **Bensieck Nelson** ADDRESS **1138 N-6**

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1948

1948

1948

1948

1948

**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.....

Registration District No. 791

File No.

Township.....

Primary Registration District No. 1003

Registered No. 3821

City St. Louis (No.)

St.

Ward)

2. FULL NAME Lawrence Dunn

(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

3. SEX

4. COLOR OR RACE

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

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

(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)

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.

FILED

11-9 1927 May 6 Starneoff

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17.

I HEREBY CERTIFY That I attended deceased from 19....., 19.....

that I last saw h..... alive on....., 18....., and that death occurred, on the date stated....., at..... m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

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

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed)....., M. D.

, 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

20. UNDERTAKER

ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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.

SUPPLEMENTARY

S-13488