

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

Do not use this space.

16604

1. PLACE OF DEATH

County.....

Registration District No.....

791

Township.....

Primary Registration District No.....

1003

City.....

(No. *St. Mary's Infirmary*)

File No.....

Registered No. : *4502*

2. FULL NAME

(a) Residence. No. *1126 East* St., *25* 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>Male</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <i>Single</i>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Don't Know*

7. AGE <i>About 67</i>	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Day Laborer*
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *Ireland*
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER *Don't Know*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Don't Know*
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER *Don't Know*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Don't Know*
(STATE OR COUNTRY)

14. INFORMANT *Sister M. Raphael Supt.*
(Address) *1536 Papin St.*

15. MAY 13 1927 FILED *Mail started off*

REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *5-12-27* 19

17. I HEREBY CERTIFY, That I attended deceased from *4-24-27*, 19, to *5-12-27*, 19, and that I last saw him alive on *5-12-27*, 19, and that death occurred, on the date stated above, at *6:20* p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic myocarditis
 93C
 97 *90B* (duration) *1* yrs. mos. da.

CONTRIBUTORY *arteriosclerosis*
(SECONDARY) (duration) *2* yrs. mos. da.

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

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

WAS THERE AN AUTOPSY? *yes*

WHAT TEST CONFIRMED DIAGNOSIS? *autopsy*

(Signed) *Eugene H. Moore*, M. D.

5-13-1927 (Address) *1536 Papin*

*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 Cemetery* DATE OF BURIAL *May 14 1927*

20. UNDERTAKER *J.H. Gubler & Co* ADDRESS *2842 Maramee*

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.

