

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

Do not use this space.

1940

1. PLACE OF DEATH  
 County Louis Registration District No. 799  
 Township Richmond Primary Registration District No. 6033  
 City Richmond Mo. St. Marys Hospital File No. 159  
 St. \_\_\_\_\_ Ward \_\_\_\_\_  
 Registered No. \_\_\_\_\_

2. FULL NAME Margaret Harrison  
 (a) Residence No. 4507 Louisiana St. Ward \_\_\_\_\_  
 (Usual place of abode) (If nonresident give city or town and State)  
 Length of residence in city or town where death occurred 50 yrs. mos. da. How long in U.S., if of foreign birth? 50 yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 4 - 1861

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>65</u>	<u>11</u>	<u>26</u>	

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

10. NAME OF FATHER James Sweeney

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

12. MAIDEN NAME OF MOTHER Mary Hanley

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

14. INFORMANT Thomas B. Harrison  
 (Address) 4507 Louisiana St.

15. FILED 6/9/27 1940 REGISTRAR J. R. Madditt

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 8<sup>th</sup> 1927

17. I HEREBY CERTIFY, That I attended deceased from 4-24, 1927, to 6/8, 1927  
 that I last saw her alive on 6/7, 1927, and that death occurred, on the date stated above, at 1:30 a.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Chronic myocarditis acute dilatation of heart  
Frac. Rt. femur 4/24/27 United.  
 (duration) 2 yrs. mos. da.  
 CONTRIBUTORY chron. interstitial nephritis  
 (SECONDARY) (duration) \_\_\_\_\_ yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED? Frac. of femur at 6168 this person  
 NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? clinical  
 (Signed) Walter M Jones, M. D.  
6-9-1927 (Address) Wall 1302g

\*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 June 10 1927

20. UNDERTAKER Cullman Bros ADDRESS 1710 N. Grand St.

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.

James  
Wall Bedg.

or

3400 Merriam St

requested to make every effort to obtain the following information  
cated by check marks, lacking from the death certificate:

Name: Margaret Harrison

Who died at: Richmond Heights June 8, 1927,  
Mo. St.

Residence: No. \_\_\_\_\_ St. \_\_\_\_\_  
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_

Sex: \_\_\_\_\_ Color or race: \_\_\_\_\_ Single, married, widowed or divorced: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Age: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_

Occupation: (a) Trade \_\_\_\_\_ (b) Industry: \_\_\_\_\_

Birthplace (State or country) \_\_\_\_\_

Birthplace of father (State or country) \_\_\_\_\_

Birthplace of mother (State or country) \_\_\_\_\_

CAUSE OF DEATH: Chronic Myocarditis  
Deletation of Heart Fracture right  
Femur  
Contributory: Chronic Interstitial Nephri-  
tid ~~X~~ Accident fall down wains steps in residence

Where was disease contracted? \_\_\_\_\_

Did operation precede death? \_\_\_\_\_ Date of \_\_\_\_\_

Was there an autopsy? \_\_\_\_\_ What test confirmed diagnosis? \_\_\_\_\_

Name of physician: Walter M. Jones

Address of physician: Wall Bldg. St. Louis, Mo.

S-19400