

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

Do not use this space.

19802

1. PLACE OF DEATH

County.....

Registration District No.....

791

1003

File No.....

15529

Township.....

Primary Registration District No.....

Registered No.....

City.....

(No. *St. Marys Hwy 14 & Papin*)

St.....

Ward.....

2. FULL NAME

Vincent Lally

(a) Residence, No.....

(Usual place of abode)

Grand Hill 6th St. + Chestnut 25

(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)

March 14, 1853

7. AGE

YEARS *74*

MONTHS *3*

DAY *—*

IF LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

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

Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

Day work

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Ireland

10. NAME OF FATHER

Patrick Lally

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ireland

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ireland

14.

INFORMANT

(Address)

*Michael Kinney
Columbus Bldg*

15.

FILED

*May 15 1927
Max Starckoff
REGISTRAR*

3 MEDICAL CERTIFICATE OF DEATH

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

6/14 1927

17.

I HEREBY CERTIFY, That I attended deceased from

May 18, 1927, to June 14, 1927

that I last saw him alive on *June 14, 1927*, and that death occurred, on the date stated above, at *3 A* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

*Chr. Myocard.
Chr. neph.*

CONTRIBUTORY (SECONDARY)

Chl. Tuberculosis (duration) *10* yrs. — mos. ds.

(duration) *10* yrs. ? mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH:

Home

DISEASE OPERATION PRECEDE DEATH:

No

DATE OF.....

WAS THERE AN AUTOPSY?

No

WHAT TEST CONFIRMED DIAGNOSIS:

Chr. Lab

(Signed)

J. V. Nakada, M. D.

6/14, 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

DATE OF BURIAL

Calvary Cemetery

June 16, 1927

20. UNDERTAKER

ADDRESS

Bensick Mehaus

1138 N 6th

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.

