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

Do not use this space.

20303

File No. .....

Registered No. 6215

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City St. Louis Mo (No. ....., Sanitarium St. ..... Ward)

2. FULL NAME Dennis McAuliffe

(a) Residence. No. 2209 Hebert St., 10th Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 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)
Male	white	Single

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

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

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
About 64			

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

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

PARENTS

10. NAME OF FATHER Unknown

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 H. Thierell
(Address) City Sam

15. FILED JUL -6 1927 Mayo C. Starkloff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-29- 1927

17. I HEREBY CERTIFY, That I attended deceased from Oct 25- 1926 to 6-29- 1927, that I last saw h. alive on 6-28- 1927, and that death occurred, on the date stated above, at 4:15 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
chronic
gastrocolitis

(duration) yrs. 8 mos. 0 ds. X

CONTRIBUTORY (SECONDARY) 106

(duration) yrs. mos. ds.

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

O DID AN OPERATION PRECEDE DEATH? no DATE OF .....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? ✓

(Signed) H. Thierell, M. D

6-29-, 1927 (Address) City Sam

*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	July 6 1927
20. UNDERTAKER	**ADDRESS**
H. Gubler Park Co	2842 Meramec

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.