

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

Do not use this space.

23117

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... Primary Registration District No. 1003
 City St. Louis (No. 2616 N. Union) St. _____ Ward _____
 Registered No. 6810

2. FULL NAME

(a) Residence. No. 2616 N. Union St. 6 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 <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>
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5A. IF MARRIED, WIDOWED, OR DIVORCED
 HUSBAND OF _____
 (OR) WIFE OF James P. Riley

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 22 - 1892

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>55</u>	<u>1</u>	<u>3</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) St. Louis
 (STATE OR COUNTRY) MO

PARENTS

10. NAME OF FATHER Francis M. Garry

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

12. MAIDEN NAME OF MOTHER Mary O'Keefe

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

14. INFORMANT James P. Riley
 (Address) 2616 N. Union

15. FILED 11 27 1927 Max C. Starkeoff
 19 _____ Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 25 19 27

17. I HEREBY CERTIFY That I attended deceased from May 16, 1924, to July 25, 1927 that I last saw her alive on July 25, 1927, and that death occurred, on the date stated above, at 8:40 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Aortic Insufficiency

CONTRIBUTORY Aneurysm
 (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) J. A. VanHoefen, M. D.

7/25, 1927 (Address) 8313 Halle Ferry

*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 28, 1927
 20. UNDERTAKER ADDRESS

Cellularium Boro 1710 N. Grand

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.

Dr. Van Hoop

8513 Wells St. , Pa.