

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

Do not use this space.

23147

**1. PLACE OF DEATH**

County..... Registration District No. **791**  
 Township..... Primary Registration District No. **1003**  
 City..... *St Louis* (No. *St Johns Hospital*)

File No.....  
 Registered No. **6842**  
 St. .... Ward)

**2. FULL NAME**

*Margaret Walsh*  
 (a) Residence. No. *4489 Delmar Ave*, *19* Ward. (If nonresident give city or town and State)  
 (Usual place of abode)

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 *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 *Martin J Walsh*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Nov 7-1854*

7. AGE	YEARS	MONTHS	DAY	IF LESS than 1 day, hrs. or min.
	<i>72</i>	<i>8</i>	<i>20</i>	

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 *Daniel Breen*

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

12. MAIDEN NAME OF MOTHER *Catherine Duggan*

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

14. INFORMANT *Thomas Walsh*  
 (Address) *4489 Delmar Ave*

15. FILED *19* *Mar 6 Starker*

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *July 27 1927*

17. I HEREBY CERTIFY, That I attended deceased from *July 1st*, 1927, to *July 27th* 1927 that I last saw him alive on *July 27th*, 1927, and that death occurred, on the date stated above, at *1230 P.M.*

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
*Carcinoma of Pancreas and extending into stomach and liver;*  
 (duration) yrs. *4* mos. ds.

CONTRIBUTORY (SECONDARY) *Chronic nephritis*  
 (duration) yrs. *6* mos. ds.

18. WHERE WAS DISEASE CONTRACTED *Home*  
 IF NOT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? *yes* DATE OF *July 27-1*  
 WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS? *at operation*  
 (Signed) *Wm P. Gleason*, M.D.

*July 28, 1927* (Address) *204 E. 13th St*  
 \*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 *Barry* DATE OF BURIAL *7-29 1927*

20. UNDERTAKER *Arthur J Donnelly 2039 Wash*

M. D.—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.

REGISTRAR

1-10-1940  
1940

1940  
1940