MARGIN RESERVED FOR BINDING

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.

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

Do not use this space.

25765

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Registration District No. 1003

City St Louis (No. Little Sisters Pr ..... St. ..... Ward)

File No. ..... Registered No. 7367

2. FULL NAME Mary Mahon

(a) Residence. No. 2209 Hebert St., 22 Ward. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 50 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): Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 19 - 1849

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
78	5	25	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housekeeper.

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

(c) Name of employer

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

PARENTS

10. NAME OF FATHER: John Mahon

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

12. MAIDEN NAME OF MOTHER: Ellen Nolan

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

14. INFORMANT: Sr. Ignace de Loyola
(Address) 2209 Hebert St.

15. FILED AUG 15 1927 19 Mary C Starkcoff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 14 Aug. 11 PM 1927

17. I HEREBY CERTIFY, That I attended deceased from Aug 7, 1927, to Aug 14, 1927 that I last saw her alive on 8/15, 1927, and that death occurred, on the date stated above, at 11 P.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Myocarditis
Chronic
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Senility
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? No. DATE OF .....

WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS? Clinical Examination

(Signed) Anthony A. Pekarski M. D

8/15, 1927 (Address) 1502 Cass Ave

*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: St Peters Mo.

DATE OF BURIAL: Aug 16 1927

20. UNDERTAKER: H Dallmeyer & Sons Co

ADDRESS: St Charles Mo