

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

Do not use this space.

28388

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... Primary Registration District No. 1003
 City St. Louis (No. 1010 S. Curving) St. _____ Ward _____

File No. _____
 Registered No. 7909

2. FULL NAME

Rose Kesney
 (a) Residence No. _____ St. 22 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 | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Female | White | Married

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

James Kesney

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

Unknown 1872

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.

abt. 55 | - | - | - | -

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)

(STATE OR COUNTRY) Ireland

10. NAME OF FATHER

Owen Fox

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 James Kesney
 (Address) 1010 S. Curving

15.

FILED SEP - 6 1927 Man & Starkoff
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9/4 19 27

17. I HEREBY CERTIFY, That I attended deceased from Sept 3, 1927, to Sept 4, 1927 that I last saw h. or alive on Sept 4, 1927, and that death occurred, on the date stated above, at 11 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Hemorrhage from
Fungus
21 (duration) yrs. mos. da.
 CONTRIBUTORY (SECONDARY) Tuberculosis
Fungus (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

8 DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) Chas. C. Hanson, M. D.
Sept 5, 1927 (Address) 2910 Chouteau

*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

Cemetery 9-6 19 27

20. UNDERTAKER ADDRESS

Arthur J. Donnelly 2039 Wash St

K. 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.

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