

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

Do not use this space.

28460

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City..... *St. Louis* (No. *4581*) *Blair* St. *Blair* Ward

File No.....
Registered No. **7989** St. _____ Ward

2. FULL NAME

Catherine Le Page
(a) Residence No. _____ St. *70* 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. 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) *Widowed*

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

Joseph Le Page

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Oct 16th 1864*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<i>62</i>	<i>10</i>	<i>21</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)

(STATE OR COUNTRY) *St. Louis*

10. NAME OF FATHER

John Sheehan

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 *Catherine Le Page*
(Address) *4581^{1/2} Blair*

15.

FILED *SEP - 8 1927* *Max C. Stanley* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *9-7-1927*

17. I HEREBY CERTIFY, That I attended deceased from *12 min.* *15 day* *1927*, to *9-6-1927*, 19 *27* that I last saw h. *w* alive on *9-6-1927*, and that death occurred, on the date stated above, at *3⁵* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Carcinoma of sigmoid

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? *Yes* DATE OF *12-17-26*

WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS *at operation*

(Signed) *A. H. [Signature]*, M. D.

9/7, 19 *27* (Address) *3102 S. Grand*

*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 *9-9 1927*

20. UNDERTAKER

ADDRESS

Arthur J. Donnelly *2039 Wash St*

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.

