

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

Do not use this space.

1. PLACE OF DEATH

County.....
Township.....
City *St. Louis Mo.* (No. *1003*)

Registration District No. **791**
1003
Primary Registration District No. *Isolation Hospital*

File No. *28539*
Registered No. **18122**
St. Ward

2. FULL NAME *Delia Connor*

(a) Residence. No. *1241 N. 8th St.* St. *25* Ward.

(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred *1* yrs. *8* mos. *21* 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 *Single*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *1-21-1926*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
1 *7* *21*

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *nil*
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN) *Mo.*
(STATE OR COUNTRY)

10. NAME OF FATHER *George Connor*

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

12. MAIDEN NAME OF MOTHER *Ella Connor*

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

14. INFORMANT *M. O'Brien*
(Address) *5600 Arizona*

15. FILED *SEP 19 1927* *Max C. Standley*
REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Sept 12 1927*

17. I HEREBY CERTIFY That I attended deceased from *Sept 12 1927* to *Sept 12 1927* that I last saw her alive on *Sept 12 1927* and that death occurred, on the date stated above, *4:20 a.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pertussis 9
157A

CONTRIBUTORY (SECONDARY) *Pneumonia*
Secondary (duration) *1 1/2* yrs. *14* mos. *—* ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH. *1241 N 8th St*

DID AN OPERATION PRECEDE DEATH? *NO* DATE OF.....
WAS THERE AN AUTOPSY? *NO*
WHAT TEST CONFIRMED DIAGNOSIS? *Clinical*
(Signed) *Wm H Garrison*, M. D.

9/12 1927 (Address) *Isolation Hospital*
*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 *Walhall* DATE OF BURIAL *9-14 1927*

20. UNDERTAKER *Arthur J. Donnelly* ADDRESS *2039 9th 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.

