

5004 N Union

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

Do not use this space.

31517

1. PLACE OF DEATH

County.....

Registration District No. *Colfax 4861 791*

Township.....

Primary Registration District No. *1003*

City *St. Louis* (No. *4700 Samfusa Ave*)

File No.....

Registered No. *8834*

St. Ward)

2. FULL NAME

(a) Residence. No. St. *7* 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

Female

4. COLOR OR RACE

W

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)

Sept 13 - 1852

7. AGE YEARS MONTHS

75

DAYS *18*
If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

House Work 108

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

92 174

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Ill

10. NAME OF FATHER

Thomas Glennon

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ireland

12. MAIDEN NAME OF MOTHER

Julia Kenney

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ireland

14.

INFORMANT

(Address)

*Chas. Brennan
4700 Samfusa Ave*

15.

FILED

OCT - 3 1927

Max B. Starosoff

REGISTER

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *10 - 1 - 1927*

17. I HEREBY CERTIFY, That I attended deceased from *Sept 29*

....., 1927, to *Oct 1*, 1927.

that I last saw her alive on *Oct 1*, 1927, and that death occurred, on the date stated above, at *1130* P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lobar Pneumonia

1010 (duration) yrs. mos. *10* da.

CONTRIBUTORY (SECONDARY) *mitral Incompetency*

Bexposure (duration) *2* yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: *4700 Samfusa Ave*

19. DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS? *Physical Examination*

(Signed) *Francis Conway*, M. D.

, 19 (Address) *5004 N Union*

*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

Ruma. Ill *Oct 4 1927*

20. UNDERTAKER

ADDRESS

Wm. F. Howard & Sons *3226 - 17th Ave*

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.

WHITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

