

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

Do not use this space.

34929

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **St. Louis** (No. **City Hospital**)

File No.

Registered No. **10074**

St.

Ward)

2. FULL NAME

(a) Residence. No. **3732 Calhoun** Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred **66** yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

male

White

Widowed

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

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

Feb 16 - 1861

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, ____ hrs. or ____ min.

66

8

24

8. OCCUPATION OF DECEASED

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

Laborer

(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 Sineally

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

Indiana

12. MAIDEN NAME OF MOTHER

Margaret Roach

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

Indiana

14.

INFORMANT (Address)

Ed. male City Hospital

15.

FILED

OV 11 1927

Mar. B. Starkeff

REGISTRAR

16. DATE OF DEATH (MONTH, DAY AND YEAR)

Nov 9 1927

17.

I HEREBY CERTIFY, That I attended deceased from **Nov 3**, 19**27** to **Nov 9**, 19**27** that I last saw h. l. m. give on **Nov 9**, 19**27** and that death occurred, on the date stated above, at **8:30 a.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis
Arterio Sclerosis
(duration) ____ yrs. ____ mos. ____ da.

CONTRIBUTORY (SECONDARY)

Chronic Interstitial nephritis (duration) ____ yrs. ____ mos. ____ da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) **J. J. Starkeff** M. D.
, 19**27** (Address) **City 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

DATE OF BURIAL

Central

Nov 12 1927

20. UNDERTAKER

ADDRESS

Bullen Kelly

4526 Easton

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.

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

Kenealy