

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

Do not use this space.

38179

1. PLACE OF DEATH

County.....

Registration District No.....

791

Township.....

Primary Registration District No.....

1003

City.....

St. Louis

(No.)

4393 Forest Park Ave

File No.....

Registered No.....

10814

St.....

Ward.....

2. FULL NAME

Bridge Grace

(a) Residence. No.

4393 Forest Park Ave

19. 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)

single

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

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

don't know

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, hrs. or min.

abt 80

8. OCCUPATION OF DECEASED

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

store keeper

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

(c) Name of employer

self

9. BIRTHPLACE (CITY OR TOWN)

Louisville

(STATE OR COUNTRY)

ky

10. NAME OF FATHER

Joe Grace

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Ireland

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

Ellen Casey

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Ireland

(STATE OR COUNTRY)

14.

INFORMANT

Mr Mary Grace

(Address)

4393 Forest Park Blvd

15.

FILED

80 - 2 1921

Max Starkoff

REGISTER

3

MEDICAL CERTIFICATE OF DEATH

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

12/2 -

1927.

17.

I HEREBY CERTIFY, That I attended deceased from Oct. 2nd, 1927, to Dec 1, 1927, that I last saw her alive on Dec 1, 1927, and that death occurred, on the date stated above, at about 12⁰⁰ a.m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Intestinal hemorrhage supposed cancer (duration) yrs. mos. 2. ds.

CONTRIBUTORY (SECONDARY)

Renal debility (duration) yrs. 10. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH.....

DATE OF.....

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed).....

usual
E. H. Spooner, M. D.

, 19 (Address) 4397 Forest Park Blvd.

*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

Calvary Cem

Dec 5 1927

20. UNDERTAKER

ADDRESS

Thos J Finnan

1519 S Grand

N. B.—Every item of information should be carefully supplied. AGE should be edited EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

