

WAR 19 1928

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

Do not use this space.

1. PLACE OF DEATH  
 County Jackson Registration District No. 398 File No. 4797  
 Township Blue Primary Registration District No. 3019 Registered No. 90  
 City Wt Washington (No. Independent Sanatorium St. Ward)

2. FULL NAME Julia Ann Cassidy  
 (a) Residence No. 530 Brookside Mt Washington (Usual place of abode)  
 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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 14 1869

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
59 0 13

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work Housewife  
 (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) Missouri

10. NAME OF FATHER Elia Weaver

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

12. MAIDEN NAME OF MOTHER Mrs Anna Weaver

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

14. INFORMANT John Cassidy  
 (Address) 530 Brookside Blvd

15. FILE Feb 1 1928 + L. COOK REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 28 1928

17. I HEREBY CERTIFY, That I attended deceased from 2/27, 1928, to 2/29, 1928, that I last saw him alive on 2/27, 2 a.m., 1928, and that death occurred, on the date stated above, at 2 a.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Cardiac Failure 11A  
Influenza 11B  
Bronchial asthma  
 (duration) yrs. mos. da.

CONTRIBUTORY Influenza (SECONDARY) (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH  
9 DID AN OPERATION PRECEDE DEATH DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY? \_\_\_\_\_  
 WHAT TEST CONFIRMED DIAGNOSIS  
 (Signed) William, M. D.  
 (Address) Fairmount Mo.

\*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 Mt St Marys DATE OF BURIAL Mar 1 1928

20. UNDERTAKER John J Sheehan ADDRESS K. C. Mo

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.

