

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

Do not use this space.

6369

PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **St. Louis, Mo.** (No. **1**)

City **Sanitarium**

File No.

Registered No. **1267**

St. Ward)

2. FULL NAME

Mary Hamilton

(a) Residence. No. **3845 1/2 Finney St.** **13** Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred **35** yrs. **4** mos. **13** da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 19, 1852.

7. AGE
YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
75 2 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 employee) **Missionary Unknown**
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)
Dublin Ireland

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT (Address)
Louis Kohler 5370 Cass St.

15. FILE NO. - 3 1929 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **2/1/28** 19

17. I HEREBY CERTIFY, That I attended deceased from 10/18/27, 19 to 2/1/28, 19 that I last saw him alive on 2/1/28, 19, and that death occurred, on the date stated above, at 9:42 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumo-pneumonia
1000
113 (duration) yrs. mos. **3** da.
CONTRIBUTORY (SECONDARY) **Emphysema of lungs**
(duration) yrs. **3** mos. **25** da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

0 DID AN OPERATION PRECEDE DEATH? **Yes** DATE OF

WAS THERE AN AUTOPSY? **Yes**

WHAT TEST CONFIRMED DIAGNOSIS? **Chinid**

(Signed) **Louis Kohler**, M. D.

2/1/28, 19 (Address) **5370 Cass St.**

*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 **St. Peter's Cemetery** **DATE OF BURIAL** **Feb 3 1928**

20. UNDERTAKER **Wm J. Rober** **ADDRESS** **1905 1/2 Grand St.**

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.

adults

