

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

Do not use this space.

6962

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... Primary Registration District No. 1005
 City St Louis (No. 1389 Union Blvd) St. _____ Ward _____

File No. _____
 Registered No. 1927

2. FULL NAME Catherine Doyle

(a) Residence, No. 1389 Union Blvd St. 5 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

2. 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) Mar 2 1883

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
44 yrs 11 18

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Forelady
 (b) General nature of industry, business, or establishment in which employed (or employer) Shoes
 (c) Name of employer _____

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

10. NAME OF FATHER John Doyle

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

12. MAIDEN NAME OF MOTHER Eliz Ronan

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

14. INFORMANT Miss Blin Smith
 (Address) 1389 Union Blvd

15. FILED 21 1928 May 6 Starckoff
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 20 1928

17. I HEREBY CERTIFY That I attended deceased from Feb 15th 1928 to Feb 20th 1928 but I last saw her alive on Feb 20th 1928 and that death occurred, on the date stated above, at 7:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

138
Lobar Pneumonia
 (duration) yrs. mos. ds. 5 ds.
 CONTRIBUTORY (SECONDARY) 10/10
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....
 0 DID AN OPERATION PRECEDE DEATH? no. DATE OF _____

WAS THERE AN AUTOPSY? no
 WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) J. J. Gallagher M. D.
121, 1928 (Address) 311-313 Wall Bldg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Calvary Cemetery DATE OF BURIAL 2-23-28 19

20. UNDERTAKER Thos J. Finnan ADDRESS 15195 Lyons

M. 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.

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