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

Do not use this space.

11388

1. PLACE OF DEATH

County..... Registration District No. 791

Township..... Primary Registration District No. 1003

City..... (No. 4417 N 19 Sw. St. ..... Ward)

File No. .....

Registered No. 3229

2. FULL NAME Margaret Conway

(a) Residence. No. 4417 N 19 Sw. St., 9 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): Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): 6-15-1867

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
60	9	5	

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): Ireland

PARENTS

10. NAME OF FATHER: Daniel Hickey

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

12. MAIDEN NAME OF MOTHER: Johana McCormack

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

14. INFORMANT: Mrs August Krull (Address) 4417 N 19 Sw

15. FILED ....., 19.. Max C. Starkoff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from 3-17-28, 19....., to 3-20-, 1928 that I last saw her alive on 3-20-28, 19....., and that death occurred, on the date stated above, at 9.45 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Haemorrhage (Apoplexy)

82A

74A

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (SECONDARY) .....

(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?.....

8 DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Examination

(Signed) Dr. G. W. Tontz, M. D

3/21, 1928 (Address) 2204a St Louis Ave

*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: Calvary Cemetery

DATE OF BURIAL: 3/23 1928

20. UNDERTAKER: W. A. Stock Und Co

ADDRESS: 2117 E. Grand

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.