

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

Do not use this space.

11684

**1. PLACE OF DEATH**

County.....

Registration District No. 70

Township.....

Primary Registration District No. 583

City St. Louis (No. City Hospital)

File No.....

Registered No. 3581

St. .... Ward)

**2. FULL NAME**

(a) Residence. No. 6033 Rocking 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 30 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

**2. SEX**

**4. COLOR OR RACE**

**5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)**

male

White

Single

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

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

June 17 - 1855

**7. AGE**

YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>74</u>	<u>9</u>	<u>6</u>	

**8. OCCUPATION OF DECEASED**

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

Janitor

(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) Massachusetts

**10. NAME OF FATHER**

John Barry

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY) Ireland

**12. MAIDEN NAME OF MOTHER**

Annal Manning

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY) Ireland

**14.**

INFORMANT

(Address)

Chas. C. Stanley  
City Hospital  
City Hospital

**15.**

FILED

30 1928

Chas. C. Stanley  
REGISTRAR

**2 MEDICAL CERTIFICATE OF DEATH**

2

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

March 23 1928

**17.**

I HEREBY CERTIFY That I attended deceased from March 19, 1928, to March 23, 1928, that I last saw him alive on March 23, 1928, and that death occurred, on the date stated above, at 8:26 a.m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Chronic Myocarditis

131

9:30

(duration) yrs. mos. ds.

**CONTRIBUTORY (SECONDARY)**

Chronic nephritis

(duration) yrs. mos. 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) Robert H. Simpson, M. D.

30, 1928 (Address) City Hospital

\*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 Cemetery

Mar 30 1928

**20. UNDERTAKER**

**ADDRESS**

J. H. Gethken

2842 Meramec

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.

PERMANENT RECORD

Darry