

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

Do not use this space.

14941

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **003**

City.....

St. Louis 5989 - Romaine pl.

File No.

[3850]

Registered No.

St.

Ward)

2. FULL NAME

(a) Residence. No. **5989 - Romaine pl.** St. **6** 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.

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~~ Widowed or
Divorced (write the word)

Widowed

5A. Is Married, Widowed, or Divorced

HUSBAND OF *the late Patrick Clines*
(OR) WIFE OF

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

Feb. 2, 1866

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1
day, hrs.
or min.

62

1

15

8. OCCUPATION OF DECEASED

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

Housework

(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)

Illinois

10. NAME OF FATHER

Sam Murphy

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ireland

12. MAIDEN NAME OF MOTHER

Don't know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ireland

14

Mrs. W. Giblin
(Address) *5989 - Romaine pl.*

15

May C. Starckoff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

April 5, 1928

17.

I HEREBY CERTIFY, That I attended deceased from *Feb 2, 1928* to *April 5, 1928* that I last saw her alive on *April 6, 1928*, and that death occurred, on the date stated above, at *6:35 p.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Coronary (Long) Lung

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?.....

DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed) *W. C. White*, M. D.

April 6, 1928 (Address) *1500A Woodmont 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

DATE OF BURIAL

Calvary Cem.

April 9, 1928

20. UNDERTAKER

1125
Address

Jos. W. Clark

Madison Ave.

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

