

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

Do not use this space.

15107

1. PLACE OF DEATH

County *St. Louis City, Independency*
 Township *5800 Arsenal St*
 City *St. Louis, Mo.*

Registration District No. *791*
 Primary Registration District No. *1003*
Independency

File No. _____
 Registered No. *4029*
 St. _____ Ward _____

2. FULL NAME

Margaret Mc Cready
 (a) Residence. No. *908 Chambers* St. *23* Ward

Length of residence in city or town where death occurred *24* yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. 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 *single*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Mar 17 - 1891*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
57 - - 21

8. OCCUPATION OF DECEASED

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

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

10. NAME OF FATHER *Richard Mc Cready*

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

12. MAIDEN NAME OF MOTHER *Sabet Mc Cready*

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

14. INFORMANT *Miss Egerger*
 (Address) *58 64 Arsenal St*

15. FILED *12 1929* *May C. Startley* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Apr - 8 1929*

17. I HEREBY CERTIFY, That I attended deceased from *7* *April* 1929, to *8* *April* 1929, that I last saw him alive on *Apr 8* 1929, and that death occurred, on the date stated above, at *11 50 a* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS

Pulmonary TB. Tuberculosis
23A
71B
 (duration) yrs. mos. da. *1* ds.
 CONTRIBUTORY (SECONDARY) *Secondary anemia*
 (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? *?*

DID AN OPERATION PRECEDE DEATH. *no* DATE OF *none*

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS. *stain - & sputum*
 (Signed) *R. Berg* M. D.

4/8 1929 (Address) *5800 Arsenal*

*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 *Apr 12 1929*

20. UNDERTAKER

J. H. Kepken ADDRESS *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.

