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.

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

Do not use this space.

File No. 22452

Registered No. 6648

1. PLACE OF DEATH

County: St. Louis — Registration District No. 1003 — Primary Registration District No. 791

Township — City: St Louis (No.) St Louis Hospital St. (Ward)

2. FULL NAME: Jane B McCloy

(a) Residence: No. Trowbridge St. Ward: Trowbridge Ill
(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): Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Mch 27-1909

7. AGE: Years 9 | Months 2 | Days 28 | If less than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At School
(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): Ill

PARENTS

10. NAME OF FATHER: Joseph McCloy
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Ill
12. MAIDEN NAME OF MOTHER: Ann Hanigan
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Ill

14. INFORMANT: Dr. McCloy
(Address): Trowbridge Ill

15. FILED: JUL 23 1928 — Jane C Warden — REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 6/25/28. 19

17. I HEREBY CERTIFY, That I attended deceased from 6/20 19 28, to 6/25/28, 19, that I last saw h. alive on 6/25/28, 19, and that death occurred, on the date stated above, at 7:45 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Staphylococcus septicaemia

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

CONTRIBUTORY (SECONDARY): Infected Cut

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

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? Culture

(Signed) Chas Leigh Thomas M. D

6/25, 19 28 (Address) Deaconess Hosp.

*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: Trowbridge Ill — DATE OF BURIAL: June 25 1928

20. UNDERTAKER: Miller Bros & Colemann — ADDRESS: 5165 Delmar Blvd