

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

Do not use this space.

31629

1. PLACE OF DEATH

County St Louis Registration District No. 0170 File No. _____
 Township Central Primary Registration District No. 62-1885 Registered No. 222
 City Richmond Heights (No. St Mary Hospital) St. _____ Ward _____

2. FULL NAME

Catherine Mears
 (a) Residence, No. 710 1/2 Grand Blvd St. _____ 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 DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF Walter Mears

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 10 - 1946

7. AGE YEARS 82 MONTHS 0 DAYS 17 If LESS than 1 day, ____ hrs. or ____ min.

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) St Louis (STATE OR COUNTRY) mo

10. NAME OF FATHER John R Coffey

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Illness (STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER Jane McGuire

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Illness (STATE OR COUNTRY) _____

14. INFORMANT James M Coffey (Address) 710 1/2 Grand Blvd

15. FILED 9/28, 1928 L E Jensen REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 27 19 28

17. I HEREBY CERTIFY That I attended deceased from Sept 28 1928 to Sept 27 1928 that I last saw her alive on Sept 27/28, 1928 and that death occurred, on the date stated above, at 7:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chor Myo Corditis
Cordis Dilation
 (duration) ____ yrs. ____ mos. ____ da.
 CONTRIBUTORY (SECONDARY) Wesley's Disease, Hypertension
Rhep (duration) ____ yrs. ____ mos. ____ da.

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

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical Symptom
 (Signed) W J O'Quinn, M. D.
9/28, 1928 (Address) Webster Branch Mo

*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 Colony Cemetery DATE OF BURIAL Sept 29 19 28

20. UNDERTAKER Wullman Bros ADDRESS 17104 Grand

WHILE 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.

1928

RECORD

THIS IS A

NO. 100

GRANT in plain text so that it may be properly identified. This statement should be carefully supplied. All names of persons mentioned in this statement should be clearly identified.

1571 Bellvue Av. R. 1/2

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
 County St. Louis Registration District No. 1190 File No.
 Township Central Primary Registration District No. 6248 Registered No. 272
 City..... (No.....) St. Ward)

2. FULL NAME Catherine Mears
 (a) Residence. No..... St. 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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) W

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

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

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

8. OCCUPATION OF DECEASED

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

(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)

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14.

INFORMANT (Address)

15.

FILED 11/19 1928 L B Jensen REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 27 1928

17. I HEREBY CERTIFY That I attended deceased from 19....., 19....., and that I last saw him alive on 19....., and that death occurred, on the date stated above, at.....

THE CAUSE OF DEATH WAS AS FOLLOWS:

Chr. Myocarditis
Coronary Atherosclerosis
Fractured rt. hip
 CONTRIBUTORY (SECONDARY) (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?.....

(Signed)....., M. D.

, 19 (Address)

*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

19

20. UNDERTAKER ADDRESS

THIS IS A PERMANENT RECORD

N. B. Every item of information shown here 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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-31629