

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

Do not use this space.

34755

1. PLACE OF DEATH

County St. Louis

Registration District No. 1170

File No. _____

Township Central

Primary Registration District No. 6245H

Registered No. 234

City St. Louis

No. St. Mary Hospital

St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 4345 Frame av

(Usual place of abode)

St. _____

Ward _____

St. Louis, Mo.

(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

male

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

Mary Maher

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

Dec 12 - 1869

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, _____ hrs. or _____ min.

59

9

28

8. OCCUPATION OF DECEASED

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

Bank Employee

(b) General nature of industry, business, or establishment in which employed (or employer)

Natl Bank Commerce

(c) Name of employer

Natl Bank Commerce

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Ireland

10. NAME OF FATHER

Jas J. Meagher

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ireland

12. MAIDEN NAME OF MOTHER

Mary Manning

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ireland

14.

INFORMANT

(Address)

Mary Meagher
4345 Frame av

15.

FILED

10/11/28

C. L. Jensen

REGISTRAR

8

MEDICAL CERTIFICATE OF DEATH

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

Oct 10 1928

17.

I HEREBY CERTIFY, That I attended deceased from Sept 6, 1928, to Oct 10, 1928, that I last saw him alive on Oct 10, 1928, and that death occurred, on the date stated above, at 5:00 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Hypertrophic Pharynx (Complete rupture)
Phyllophorin - Pyelitis
Diabetes mellitus - Arteriosclerosis

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

CONTRIBUTORY

Acute cardiac Dilatation

(SECONDARY)

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

18. WHERE WAS DISEASE CONTRAICTED?

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? yes DATE OF Sept 10 Oct. '28

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? laboratory tests.

(Signed) Allen J. Meagher, M. D.

1928, 19 (Address) 2146 2 Herand Blvd

*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

Oct 13 1928

20. UNDERTAKER

Thos J Finnan

ADDRESS

1519 S Grand

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.

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WRITE PLAINLY, WITH UNFADING INK--THIS IS A
-Every item of information should be carefully supplied.
IF AROUND
E OF DEATH in plain terms, so that it may be understood.

1511
21482
Barnes
Barnes

**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. 1170

File No.

Township Richmond Hts

Primary Registration District No. 6248

Registered No. 234

City Richmond Hts (No.) St. Ward)

2. FULL NAME

James F. Meagher

(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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 12-1869

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 58 9 28

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 12/4 19 28 C. L. Jensen REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 10 1928

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

THE CAUSE OF DEATH WAS AS FOLLOWS:

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

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-34755