

JAN 28 1928

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

Do not use this space.

42392

1. PLACE OF DEATH
County St Louis Registration District No. 289 File No. _____
Township Central Primary Registration District No. 60 33B Registered No. 356
City (No. 2638 Lynchburg St. _____ Ward) _____

2. FULL NAME Jane F. Minard
(a) Residence No. 2638 Lynchburg 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 James F. Minard

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Don't know

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>abt 74</u>				

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

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

10. NAME OF FATHER James Fitzmaurice

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. INFORMANT Jane F. Minard
(Address) 2638 Lynchburg

15. FILED 12/18 1928 Walla Tracy M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 3 1928

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Valvular Heart Disease (duration) 3 yrs. mos. da.

Bronchitis (duration) _____ yrs. mos. da.

Fracture Hip (duration) _____ yrs. mos. da.

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

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

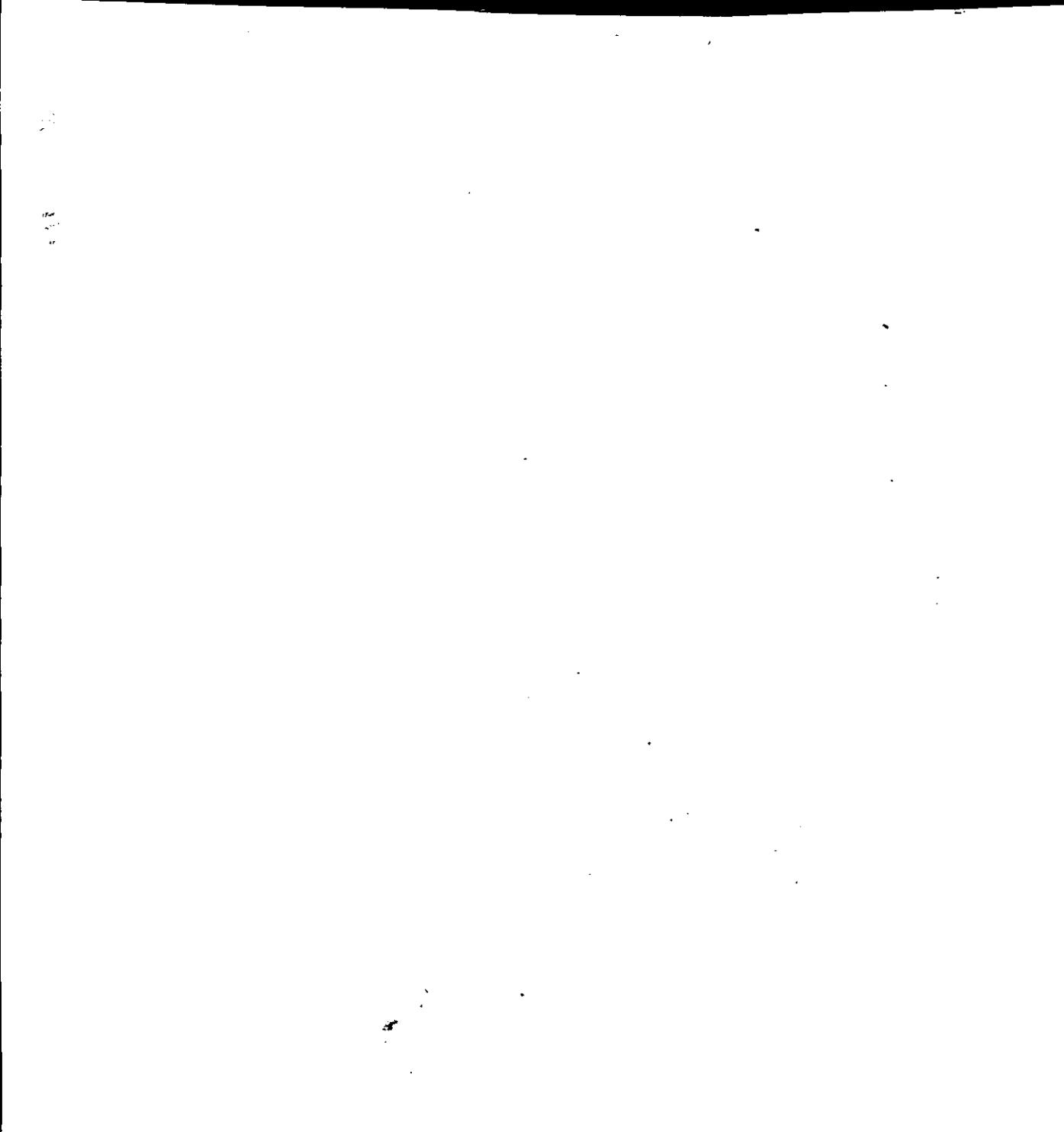
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) John A. For M. D.
(Address) 1492 Woodlawn

*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 Bellevue Hosp DATE OF BURIAL 12/6 1928

20. UNDERTAKER Thos J. Liscan ADDRESS 1819 S. Grand



**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
Township Central
City St. Louis (No.) St. Ward

Registration District No. 789
Primary Registration District No. 6033 B

File No.
Registered No. 336

2. FULL NAME

Jane F. Minard

(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) M

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 12/16 1928 Rolla Bracy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 3 1928

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Valvular Heart Disease

CONTRIBUTORY (SECONDARY) Bronchitis & Fractured Hip from a Fall. (duration) 5 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED 185 IF NOT AT PLACE OF DEATH... DID AN OPERATION PRECEDE DEATH... DATE OF...

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL 19... 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.

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

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

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