

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

Do not use this space.

c6
43654-48

1. PLACE OF DEATH

County.....

Registration District No. **791**

File No.

Township.....

Primary Registration District No. **1003**

Registered No. **82**

City *St Louis* (No. *3017*)

Magallan Ave

St. Ward

2. FULL NAME

Mary Sparrow

(a) Residence. No. *3017 Magallan St.* 17 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

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Female White Widowed

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

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

Unknown

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, hrs. or min.

65 unknown

8. OCCUPATION OF DECEASED

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

As Nurse

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

Home work

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

New York

(STATE OR COUNTRY)

New York

10. NAME OF FATHER

Don't Know

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Don't Know

12. MAIDEN NAME OF MOTHER

Fitzpatrick

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Don't Know

14.

INFORMANT

(Address)

*Lillian Sparrow
2017 E Magallan Ave*

15.

FILED

-2 1928

May C. Barker
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

Dec. 31 1928

17.

I HEREBY CERTIFY, That I attended deceased from 19....., to 19....., and that I last saw him alive on 19....., and that death occurred, on the date stated above, at 50..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

*Chronic Myocarditis
936*

CONTRIBUTORY (SECONDARY)

*97 (duration) yrs. mos. ds.
Arterio Sclerosis (General)*

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF BIRTH.....

19. DID AN OPERATION PRECEDE DEATH?

DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed).....

W. Kerner M.D.

(Address)

112 Dep Crown

*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

St Peter + Paul

Jan 4 1929

20. UNDERTAKER

J H Kelken

ADDRESS

2630 Grassie

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.

