

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

Do not use this space.

3595

1. PLACE OF DEATH

County.....

Registration District No. **791**

File No.

Township.....

Primary Registration District No. **1003**

Registered No. **185**

City **St. Louis Mo.** (No. **5041**)

Chippewa Ave

St. Ward)

2. FULL NAME

Margaret E. Delaney

(a) Residence. No. **5041 Chippewa** St., **14** Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred **18** 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 **John Delaney**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **5-2-18-1914**

7. AGE YEARS **24** MONTHS **8** DAYS **1** IF LESS than 1 day, hrs. or min.

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

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

10. NAME OF FATHER **John Sullivan**

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

12. MAIDEN NAME OF MOTHER **Mary Shea**

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

14. INFORMANT (Address) **Mrs. Catherine Sullivan 5041 Chippewa Ave**

15. FILED **Jan 3 1929** REGISTRAR **C. Baker**

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Jan 3, 1929**

17. I HEREBY CERTIFY That I attended deceased from **Oct 10, 1915** to **Jan 3, 1929** that I last saw him alive on **Jan 1, 1929**, and that death occurred, on the date stated above, at **12:30 a.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS: **131 Pneumonia - bacterial**

CONTRIBUTORY (SECONDARY) **phonic** (duration) **10** yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED **at home** 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) **F.R. Dinger**, M. D. (Address) **3701 Washington**

*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 **Green Mount Cem Co** DATE OF BURIAL **1-5-1929**

20. UNDERTAKER **Kuegshauss & Co** ADDRESS **433-8**

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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3701 Westminster Ave
Before 12.9.77.