

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

Do not use this space.

4067

1. PLACE OF DEATH

County..... Registration District No. *791*
 Township..... Primary Registration District No. *11003*
 City..... *St. Louis* (No. *St. Johns Hospital*)..... St. Ward)

File No.
 Registered No. *684*

2. FULL NAME

Helen Gleason
 (a) Residence. No. *6421 S. Kingshighway* St. *7* 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 *Edward Gleason*
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Aug 19 - 1890*
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. *38 4 23*
 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) *Missouri*
 10. NAME OF FATHER *John Luby*
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) *St. Louis* (STATE OR COUNTRY) *Missouri*
 12. MAIDEN NAME OF MOTHER *Dont know*
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *St. Louis* (STATE OR COUNTRY) *Missouri*

14. INFORMANT *Edward Gleason* (Address) *6421 S. Kingshighway*

15. FILED *17 1929* *Max C. Barker* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Jan 12 1929*
 17. I HEREBY CERTIFY, That I attended deceased from *Jan 9*, 19*28*, to *Jan 12*, 19*29*, that I last saw h. *ev* alive on *Jan 12*, 19*28* and that death occurred, on the date stated above, at *9450 m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
131 Cerebral hemorrhage
820

CONTRIBUTORY *Cardiovascular disease* (SECONDARY) (duration) *5* yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED *NOT AT PLACE OF DEATH?*
 DID AN OPERATION PRECEDE DEATH? DATE OF _____
 WAS THERE AN AUTOPSY? _____
 WHAT TEST CONFIRMED DIAGNOSIS *Otheras Test*
 (Signed) *Alphonse M. Graham*, M. D.
 (Address) *2206 North 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 *Calvary Cemetery* DATE OF BURIAL *1/16 1929*

20. UNDERTAKER *Arthur J. Donnelly* ADDRESS *2039 Wood St*

N. B.—Every item of information should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION

235

1030 m - 10h