

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

Do not use this space.

7951

1. PLACE OF DEATH

County St. Louis Registration District No. 7170
 Township Central Primary Registration District No. 6248H
 City Richmond Pt. Mo. (Name of Hospital) St. Mary's Hospital
 File No. _____ Registered No. 35
 St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 73121 2111 Ave St. _____ Ward. St. Louis Mo.
 (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 <u>Female</u>		4. COLOR OR RACE <u>White</u>		5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Widowed</u>	
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>John M. Colgin</u>					
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>12-23-1847</u>					
7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.	
	<u>81</u>	<u>1</u>	<u>13</u>		
8. OCCUPATION OF DECEASED					
(a) Trade, profession, or particular kind of work <u>At Home</u> ⁹⁴ ₁₀₆					
(b) General nature of industry, business, or establishment in which employed (or employer) <u>99</u>					
(c) Name of employer _____					

9. BIRTHPLACE (CITY OR TOWN) Pittsburgh
 (STATE OR COUNTRY) Penn.

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT John M. Colgin
 (Address) 4131 Carter Ave

15. FILED 2/7 19 29 C L Jensen
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 6 19 29

17. I HEREBY CERTIFY, That I attended deceased from _____, 1929, to _____, 1929.
 That I last saw him alive on Feb 5, 1929, and that death occurred, on the date stated above, at 6:30 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chy. bronchitis
complicating
arteriosclerosis
 (duration) yrs. mos. da.
 CONTRIBUTOR (SECONDARY) Cerebral Aneurysm
 (duration) yrs. mos. da.

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

19. DID AN OPERATION PRECEDE DEATH? Yes DATE _____

20. WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS?
Autopsy
 (Signed) J. H. Suddell, M. D.
 (Address) 2106 Grand

*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 19

20. UNDERTAKER H. A. Stock and Co ADDRESS 21176 Grand

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.

MAR 27 1929

WHILE PRINTING, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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