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

Do not use this space.

12706

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City St. Louis Mo. (No. 1827 Bacon St. ..... St. ..... Ward)

File No. .....

Registered No. 3241

2. FULL NAME Moriah Tracy

(a) Residence. No. 1827 Bacon St. St., 11 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: 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: Joseph Tracy

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Dec 1, 27, 1873

7. AGE: Years 55 | Months 2 | Days 28 | 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): — — — —
(c) Name of employer: — — — —

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Washington D.C.

PARENTS

10. NAME OF FATHER: Robert Pilkington
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Ireland
12. MAIDEN NAME OF MOTHER: Ellen Hardy
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Ireland

14. INFORMANT: Joseph Tracy
(Address) 1827 Bacon St.

15. FILED MAR 15 1929, 19.. Max C. Stanley
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): March 13 1929

17. I HEREBY CERTIFY, That I attended deceased from March 7th, 1929, to March 13, 1929, that I last saw her alive on March 12, 1929, and that death occurred, on the date stated above, at 10 15 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Double Bronchial Pneumonia

(duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (SECONDARY): Valvular Disease of Heart

(duration) ..... yrs. ..... mos. 6 ds.

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

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) [signature], M. D.

March 14, 1929 (Address) 2500 Wandewater

*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: Mount Olive Cemetery

DATE OF BURIAL: Mar. 16, 1929

20. UNDERTAKER: J. J. Quinn

ADDRESS: 1553 N. Grand Blvd.

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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