

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

Do not use this space.

13046

1. PLACE OF DEATH

County.....

Registration District No. **791**

Towship.....

Primary Registration District No. **MOO3**

City **St. Louis** (No. **4743 Beacon**)

File No.

Registered No. **3600**

St. Ward

2. FULL NAME

Margaret Moehlman

(a) Residence. No. **4743 Beacon** St. **7** Ward.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred **15** yrs. — mos. — ds. How long in U.S., if of foreign birth? **15** 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

Married

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

Sep. 29, 1873

7. AGE

YEARS	MONTHS	DAYS	if LESS than 1 day, hrs. or min.
55	5	23	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **Housework**
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

Not known

(STATE OR COUNTRY)

Ireland

10. NAME OF FATHER

Michael McShane

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Not known

(STATE OR COUNTRY)

Ireland

12. MAIDEN NAME OF MOTHER

Catherine Reddington

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Not known

(STATE OR COUNTRY)

Ireland

14. INFORMANT

Ernest Moehlman
 (Address) **4743 Beacon Ave.**

15. FILED

Mar 29 1929
Ray E. Stankley
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Mar 22 1929**

17. I HEREBY CERTIFY, That I attended deceased from March 16, 1929, to March 22, 1929, that I last saw her alive on March 22, 1929, and that death occurred, on the date stated above, at 6:45 P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Disease: Labor pneumonia
100

CONTRIBUTORY (SECONDARY)

10/10
 (duration) yrs. mos. 9 da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: **4743 Beacon**

DID AN OPERATION PRECEDE DEATH? **no** DATE OF

WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS? **Clinical**

(Signed) **R. B. Cappel**, M. D.

, 19 (Address) **3239 Franklin**

*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

Calvary Cem **Mar. 25, 1928**

20. UNDERTAKER

ADDRESS

Goodman **3934 N. 20**

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

23
15
15
15

