

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

Do not use this space.

16143

1. PLACE OF DEATH

County St. Louis Mo. Registration District No. 791 File No. _____
 Township St. Louis Primary Registration District No. 1003 Registered No. 4176
 City St. Louis (No. Children Hospital) St. _____ Ward _____

2. FULL NAME

John McCloskey
 (a) Residence. No. 3932 Labadie 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. 2 mos. 25 ds. How long in U.S., if of foreign birth? yrs. _____ mos. _____ ds. _____

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male **4. COLOR OR RACE** white **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** Single
(write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1-11-1929

7. AGE YEARS MONTHS DAYS **IF LESS than 1 day, hrs. or min.**
2 20 _____

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none Child
 (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 James M. Clokey

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

12. MAIDEN NAME OF MOTHER Cecilia Martin

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) St. Louis
 (STATE OR COUNTRY) Missouri

14. INFORMANT E. Gray
 (Address) 301 S. Kings Highway

15. FILED May 19 1929 May C. Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-6 1929

17. I HEREBY CERTIFY, That I attended deceased from April 6, 1929, to April 6, 1929
 that I last saw him alive on April 6, 1929, and that death occurred, on the date stated above, at 10:10 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

9
76R
Pertussis
about (duration) yrs. _____ mos. 14 ds.

CONTRIBUTORY Emphysema (non epidemic)
 (SECONDARY) (duration) yrs. _____ mos. 2 ds.

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

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____
20. WAS THERE AN AUTOPSY? no

21. WHAT TEST CONFIRMED DIAGNOSIS? Examination
 (Signed) A. C. Edwards, M. D.
4-7-, 1929 (Address) 500 S. Kings Highway

*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** April 9 1929

20. UNDERTAKER Mullen and Co. 5165 Alameda **ADDRESS**

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.

MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS IS A PERMANENT RECORD

