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

Do not use this space.

16373

1. PLACE OF DEATH

County ..... Registration District No. 791 1003 File No. 4414

Township ..... Primary Registration District No. ..... Registered No. .....

City St. Louis Mo. (No. 2505 Howard St. ..... St. ..... Ward)

2. FULL NAME William McLaughlin

(a) Residence. No. 2505 Howard St., 20 Ward. (If nonresident give city or town and State)
(Usual place of abode)

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: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): S

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Aug. 3, 84

7. AGE: Years 45 | Months 8 | Days 12 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Paperhanger
(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): St. Louis Mo.

PARENTS

10. NAME OF FATHER: Michael McLaughlin
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Ireland
12. MAIDEN NAME OF MOTHER: Margaret Crowley
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): St. Louis Mo.

14. INFORMANT (Address): Margaret McLaughlin

15. FILED APR 16 1929 Max C. Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Found dead April 16 1929

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19....., that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at 5:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Haemorrhage of Brain (Fractured Skull)

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

CONTRIBUTORY (SECONDARY): Manner and Cause of Same Not Ascertained

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

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

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

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) J. W. Kemer, M.D.

4/16 1929 (Address) Dep. Coron

*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: Apr. 18 1929

20. UNDERTAKER: J. J. Quinn | ADDRESS: 1530 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.