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

Do not use this space.

19560

1. PLACE OF DEATH

County ..... Registration District No. 791

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

City St Louis Mo (No. 3305 Franklin ave. St. ..... Ward)

File No. .....

Registered No. 5160

2. FULL NAME Maggie Casey

(a) Residence. No. 3305 Franklin St., 21 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: Colored

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

5A. IF MARRIED, ~~WIDOWED, OR DIVORCED~~ HUSBAND OF (OR) ~~WIFE OF~~ James Casey

6. DATE OF BIRTH (MONTH, DAY AND YEAR) not Known

7. AGE: about 77 YEARS; MONTHS ?; DAYS ?; If LESS than 1 day, ... hrs. or ..... min.

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

PARENTS

10. NAME OF FATHER Tobe Wilson

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

12. MAIDEN NAME OF MOTHER not Known

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

14. INFORMANT James Casey
(Address) 3305 Franklin ave

15. FILED ....., 19..... [signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-4- 1929

17. I HEREBY CERTIFY, That I attended deceased from 5-2-29 5-4-, 1929, to ....., 19..... that I last saw her alive on 5-4-, 1929, and that death occurred, on the date stated above, at 3:45 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bronchial Asthma non Tubercular (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Acute dilatation of heart (duration) 3 yrs. 4 mos. 10 ds.

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

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

WAS THERE AN AUTOPSY? no.

WHAT TEST CONFIRMED DIAGNOSIS? History & Physical findings

(Signed) [signature], M.D.

5-6-, 1929 (Address) 3308 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: Washington Park

DATE OF BURIAL: 5-8-1929

20. UNDERTAKER: W S Wade

ADDRESS: 4202 Finney

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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Dr. Dorsey
Peoples Finance