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

Do not use this space.

29285

File No. 8422

Registered No.

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1203

City St. Louis Mo (No. 4144 Lexington St. ..... Ward)

2. FULL NAME Matthew J Hannon

(a) Residence. No. 4144 Lexington St., 10 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Male	White	Married

5A. IF MARRIED, ~~WIDOWED, OR DIVORCED~~ HUSBAND OF ~~(OR) WIFE OF~~ Clara Meyers Hannon

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 24-1869

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	60	6	22	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Clerk Assessors Office
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (CITY OR TOWN) New York
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Michael Hannon

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

12. MAIDEN NAME OF MOTHER Johanna Drury

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

14. INFORMANT Clara Hannon
(Address) 4144 Lexington

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

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 16 1929

17. I HEREBY CERTIFY, That I attended deceased from Aug 1, Aug. 1, 1929 to Aug 16, 1929 that I last saw h. alive on Aug 15, 1929 and that death occurred, on the date stated above, at 11:15 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chr. myocarditis
Chr. nephritis

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

CONTRIBUTORY (SECONDARY) Gangrene of foot.

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

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH .....
DID AN OPERATION PRECEDE DEATH? No DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) A H Aid, M. D.
, 19 (Address) 6194 Delmar

*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 Cemetery	Aug 20 1929
20. UNDERTAKER	ADDRESS
Stroot & Carroll	4600 Natl Bldg

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

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.