

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

Do not use this space.

29479

1. PLACE OF DEATH

County..... Registration District No..... File No.....
 Township..... Primary Registration District No..... Registered No. **8658**
 City St. Louis (No. 5370 Cote Brillaud) St. Ward)

2. FULL NAME

Kate M. Scott
 (a) Residence. No. 5370 Cote Brillaud St. 6 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 <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Widow</u>	
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBANDS OF (OR) WIFE OF <u>M. Scott</u>			
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>May 9 - 1860</u>			
7. AGE	YEARS <u>69</u>	MONTHS <u>3</u>	DAYS <u>14</u>
	If LESS than 1 day, hrs. or min.		

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work at Home
 (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) Illinois

PARENTS	10. NAME OF FATHER <u>John Mahoney</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN)..... (STATE OR COUNTRY) <u>Illinois</u>
	12. MAIDEN NAME OF MOTHER <u>Unknown</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN)..... (STATE OR COUNTRY) <u>Illinois</u>

14. INFORMANT Thomas Scott
 (Address) 5370 Cote Brillaud

15. FILED..... 19.....
 REGISTER

MEDICAL CERTIFICATE OF DEATH

15. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 23 19 29
 17. I HEREBY CERTIFY, That I attended deceased from 8:22:24 19..... to 8:23:4 19.....
 that I last saw her alive on 8:23:4 19..... and that death occurred, on the date stated above, at 11:30 P. m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Cerebral Apoplexy

CONTRIBUTORY (SECONDARY) Hypertension
 (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?.....
 WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) Albert A. Denk M. D.
9:24 1929 (Address) 5300 W. Coe

*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 <u>Calvary Cemetery</u>	DATE OF BURIAL <u>Aug 26</u> 19 <u>29</u>
20. UNDERTAKER <u>Callum & Sons</u>	ADDRESS <u>1100 N. Grand</u>

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.

Dr. A. A. Kent

5300 Boston St

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