

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

Do not use this space.

32132

**1. PLACE OF DEATH**

County..... Registration District No. 791  
Township..... Primary Registration District No. 10.3  
City St. Louis (No. 4902, Argyle)

File No. ....  
Registered No. 9178  
St. .... Ward

**2. FULL NAME**

(a) Residence. No. 4842 Greer av. 6 Ward. (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 White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown 1876

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, .....hrs. or .....min.  
abt. 53 Unknown

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

10. NAME OF FATHER Patrick Tethers

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

12. MAIDEN NAME OF MOTHER Lydian Gaffney

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

14. INFORMANT John Tethers  
(Address) 4842 Greer av.

15. FILED SEP 2 1929 Max J. Tomlin  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept. 12 1929

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19..... that I last saw h..... alive on ..... and that death occurred, on the date stated above, ..... 6..... m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Acute Peritonitis  
following Perforated  
121A  
129 Appendix  
..... (duration) ..... yrs. .... mos. .... ds.  
CONTRIBUTORY (SECONDARY) ..... (duration) ..... yrs. .... mos. .... ds.

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

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

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS?  
(Signed) J. W. Fernon M. D.  
9/13, 1929 (Address) Dep. Comm.

\*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 DATE OF BURIAL 9-14 1929  
ADDRESS

20. UNDERTAKER Arthur J. Donnelly 2039 Grand St

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.

