

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

Do not use this space.

32418

1. PLACE OF DEATH

County..... Registration District No. 791
Township..... Primary Registration District No. 1003
City St Louis (No. Christen Hospital)

File No.....
Registered No. 9516
St..... Ward)

2. FULL NAME

Mamie O Neill
(a) Residence. No. 3709 Cass Ave St. 11 Ward. (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Frank
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 3-1881
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
47 9 22

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) at home
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) St Louis Mo

10. NAME OF FATHER Richard Terrell

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

12. MAIDEN NAME OF MOTHER Alice Brady

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

14. INFORMANT Frank O Neill

(Address) 3709 Cass Ave

15. FILED 1929 REGISTRAR [Signature]

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 23 1929

17. I HEREBY CERTIFY, That I attended deceased from 9/11/29, 1929, to 9/23/29, 1929 that I last saw him last alive on 9/23/29, 1929, and that death occurred, on the date stated above, at 11/2/50/10 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

myocarditis acute
93R
112
(duration) yrs. mos. 10 ds.

CONTRIBUTORY (SECONDARY) Bronchial Asthma
non tubercular (duration) ? yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

19. DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) [Signature], M. D.

9/24/29 (Address) 3108 Cass Ave

*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

balcony Sept 26 1929

20. UNDERTAKER ADDRESS

Koullers Kelly 4526 Easton

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.

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

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