

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

Do not use this space.

1. PLACE OF DEATH

County.....

Registration District No.....

Township.....

Primary Registration District No.....

City.....

(No.)

791

1003

32595

File No.....

Registered No.....

9715

St.....

Ward)

2. FULL NAME

(a) Residence. No.....

(Usual place of abode)

St.....

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

Hugh Kelly

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

2/28/1876

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

abt. 53 - -

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)

St Louis

10. NAME OF FATHER.....

Martin Miskel

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....

(STATE OR COUNTRY)

Ireland

12. MAIDEN NAME OF MOTHER.....

Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....

(STATE OR COUNTRY)

Ireland

14. INFORMANT.....

(Address)

Hugh J Kelly

2220 1/2 St

15.

FILED

-1 1929

Max E. Stahlhoff

REGISTRAR

2

MEDICAL CERTIFICATE OF DEATH

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

Sept 28th 19 29

17.

I HEREBY CERTIFY, That I attended deceased from July 3rd 1928, to Sept 28th 19 29 that I last saw her alive on Sept 28th 19 29 and that death occurred, on the date stated above, at 10:35 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cholelithiasis chr

12h

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

1 DID AN OPERATION PRECEDE DEATH?.....

yes DATE OF 3/25/29 and

WAS THERE AN AUTOPSY?.....

no

WHAT TEST CONFIRMED DIAGNOSIS?.....

Operation

(Signed)

J J Gallagher

M. D.

9/30, 1929 (Address)

311-313 4th wall Bldg

*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

Cemetery

10-2-1929

20. UNDERTAKER

ADDRESS

Arthur J Donnelly

2039 North 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.

11/10/1910
Hill Road

Wool Bedg

1. 100
 2. 100
 3. 100
 4. 100
 5. 100
 6. 100
 7. 100
 8. 100
 9. 100
 10. 100
 11. 100
 12. 100
 13. 100
 14. 100
 15. 100
 16. 100
 17. 100
 18. 100
 19. 100
 20. 100
 21. 100
 22. 100
 23. 100
 24. 100
 25. 100
 26. 100
 27. 100
 28. 100
 29. 100
 30. 100
 31. 100
 32. 100
 33. 100
 34. 100
 35. 100
 36. 100
 37. 100
 38. 100
 39. 100
 40. 100
 41. 100
 42. 100
 43. 100
 44. 100
 45. 100
 46. 100
 47. 100
 48. 100
 49. 100
 50. 100
 51. 100
 52. 100
 53. 100
 54. 100
 55. 100
 56. 100
 57. 100
 58. 100
 59. 100
 60. 100
 61. 100
 62. 100
 63. 100
 64. 100
 65. 100
 66. 100
 67. 100
 68. 100
 69. 100
 70. 100
 71. 100
 72. 100
 73. 100
 74. 100
 75. 100
 76. 100
 77. 100
 78. 100
 79. 100
 80. 100
 81. 100
 82. 100
 83. 100
 84. 100
 85. 100
 86. 100
 87. 100
 88. 100
 89. 100
 90. 100
 91. 100
 92. 100
 93. 100
 94. 100
 95. 100
 96. 100
 97. 100
 98. 100
 99. 100
 100. 100