

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

Do not use this space.

38698

1. PLACE OF DEATH

County.....
Township.....
City..... *St. Louis* (No. *1554 Nebraska*)

Registration District No. *701*
Primary Registration District No. *701*

File No.....
Registered No. *11115*
St. Ward)

2. FULL NAME

(a) Residence. No. St. *123* Ward.

(Usual place of abode)
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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Widowed*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *May 29 1865*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
64 5 13

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work *Stein clerk*
(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) *England*

10. NAME OF FATHER *Thomas Duddy*

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

12. MAIDEN NAME OF MOTHER *Mary Heines*

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

14. INFORMANT *Michael J Duddy* (Address) *1554 Nebraska*

15. FILED *11 1929* 19 *11 1929* *Earl C Stanley* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from *Oct 13*, 1929, to *Nov 12*, 1929, that I last saw him alive on *Nov 12 1929*, and that death occurred, on the date stated above, at *6:55* p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Apoplexy

7 2 A
8 2 8 (duration) yrs. *1* mos. ds.

CONTRIBUTORY (SECONDARY) *Mitral Insufficiency* (duration) *1* yrs. mos. ds.

18. WHERE AND DISEASE CONTRACTED

At home IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? *No* DATE OF

WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) *J. Louis Schuchat*, M. D. *Nov 13 1929* (Address) *2200 Chouteau av*

*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 *11-15 1929*

20. UNDERTAKER ADDRESS

Arthur J Dornnelly 2039 Ward 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.

15-8-253

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