

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

Do not use this space.

39064

1. PLACE OF DEATH

County..... Registration District No. 791
Township..... Primary Registration District No. 1003
City St Louis (No. 27111 Virginia) St. Ward)

File No.
Registered No. 11544
St. Ward)

2. FULL NAME

Annie Donnelly
(a) Residence. No. St. 17 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 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 Gas Donnelly
6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 13 1910
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
59 8 11

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) Brighton
(STATE OR COUNTRY) Ill

10. NAME OF FATHER Thos O'Donnell

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

12. MAIDEN NAME OF MOTHER Ann Ward

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

14. INFORMANT James Donnelly
(Address) 27111 Virginia

15. FILED NOV 26 1929 Max C. Anderson
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 24 1929

17. I HEREBY CERTIFY, That I attended deceased from Nov 8 1929, to Nov 23 1929, and that I last saw him alive on Nov 23 1929, and that death occurred, on the date stated above, at 10:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

apoplexy
cerebral hemorrhage
72A (duration) yrs. mos. 5 ds.
CONTRIBUTORY (SECONDARY) chronic interstitial
nephritis (duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? no DATE OF.....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) McCaines M. D.
11/25 1929 (Address) 370 Meno 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 Calvary DATE OF BURIAL Nov 27 1929

NO. UNDERTAKER Harrigan + Shephard ADDRESS 4415 Washington
Union

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.

PARENTS 2 1 5

