

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

Do not use ink

3225
~~3194~~
~~2654~~

1. PLACE OF DEATH

County.....

Registration District No. **791**
1003

Township.....

Primary Registration District No.

City *St. Louis*

(No. *City Hospital*)

File No.
Registered No. **721**
St. Ward)

2. FULL NAME

(a) Residence. No. *219 N 21* St. *21* Ward.
(Usual place of abode)

Length of residence in city or town where death occurred *59* yrs. *4* mos. *29* 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) *widow*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Aug 23, 1870*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *8-23-1870*

7. AGE	YEARS	MONTHS	DAY	IF LESS than 1 day,hrs. ormin.
	<i>59</i>	<i>4</i>	<i>29</i>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. *Salesman*
(b) General nature of industry, business, or establishment in which employed (or employer) *unknown*
(c) Name of employer *unknown*

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) *Missouri*

10. NAME OF FATHER *Alexander Lefferty*

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

12. MAIDEN NAME OF MOTHER *Catherine McAndrew*

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

14. INFORMANT

(Address) *City Hospital*

15. FILED

May 22, 1935 *May C Starbuck* REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Jun 21 1935*

17. I HEREBY CERTIFY, That I attended deceased from *Jun 18 1935* to *Jun 21 1935* (that I last saw him alive on *Jun 21 1935*, and that death occurred, on the date stated above, at *3:30 p.m.*)

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrhage (Left) "apoplexy"
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) *Hypertension - arteriosclerosis*
(duration) ? yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED? *at home*
IF NOT AT PLACE OF DEATH *219 No. 2, St*

DID AN OPERATION PRECEDE DEATH? *no* DATE OF

WAS THERE AN AUTOPSY? *no*
WHAT TEST CONFIRMED DIAGNOSIS? *Blood Pressure*
(Signed) *B Margulies*, M. D.

1/rr, 1930 (Address) City Hospital

*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 *Bellefontaine Cem. Jun 23 1935* DATE OF BURIAL

20. UNDERTAKER *Sharkey Funeral Parlor* ADDRESS *4555 Washington St. Be.*

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.

150-1-172

Safford