

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

Do not use this space.

6794

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... Primary Registration District No. 1003
 City St. Louis (No. 5790 Kingsbury Place St. Ward)

File No.
 Registered No. 1630

2. FULL NAME

John C. Healy
 (a) Residence. No. 5790 Kingsbury Pl. St. 5 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 male 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 Julia R. Healy

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 13 - 1870

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
60 1 1

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Real-Estate Dealer
 (b) General nature of industry, business, or establishment in which employed (or employer).....
 (c) Name of employer Himself

9. BIRTHPLACE (CITY OR TOWN) Cornington (STATE OR COUNTRY) Wis.

10. NAME OF FATHER Thomas Healy

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

12. MAIDEN NAME OF MOTHER Hannah Lane

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

14. INFORMANT Julia R. Healy (Address) 5790 Kingsbury Pl.

15. Wm C. Stanley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 14 1930

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1929 to Feb 14 1930 that I last saw him alive on Feb 12 1930, and that death occurred, on the date stated above, at 5:40 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Isotonic Bronchopneumonia
90A
94 Angiemia Pulvis (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 90A (duration) yrs. mos. ds.

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

8 DID AN OPERATION PRECEDE DEATH? DATE OF.....

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS (Signed) L. H. Thompson M. D. 7/15, 1930 (Address) 626 Metropolitan 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 Cemetery DATE OF BURIAL Feb. 17 1930

20. UNDERTAKER Callaway Bros ADDRESS 1710 W. Grand 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.

154
 202

PARENTS

INFORMANT

FILED

REGISTRAR

metropolitan Bed

8³⁰ to 9³⁰