

**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. **791**

Township.....

Primary Registration District No. **1003**

City **St. Louis** (No. **719 N. Spring Ave**)

File No. **7262**

Registered No. **2139**

**2. FULL NAME**

(a) Residence. No. **19** St. **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)

*widow*

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

*Frank J Dougherty*

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

*Unknown 1870*

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, ..... hrs. or ..... min.

*abt 60*

*Unknown*

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 Missouri*

10. NAME OF FATHER

*Thomas Coote*

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

*St. Louis Missouri*

12. MAIDEN NAME OF MOTHER

*Kate Mc Guire*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

*St. Louis Missouri*

14.

INFORMANT

(Address)

*Non Dougherty*

*719 N. Spring Ave*

15.

FILED

19

*Mar C Stanley*

REGISTRAR

**3 MEDICAL CERTIFICATE OF DEATH**

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

*Feb 28 1930*

17.

I HEREBY CERTIFY, That I attended deceased from *Jan 15*

1930 to *Feb 28* 1930

that I last saw h. *alive* on *Feb 20* 1930 and that death occurred, on the date stated above, at *1 P* m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

*Angina Pectoris*

*Adipositas mellitus*

(duration) ..... yrs. .... mos. .... ds.

CONTRIBUTORY (SECONDARY)

*arteriosclerosis*

(duration) ..... yrs. .... mos. .... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) *L. H. Thompson* M. D.

31. 1930 (Address) *616 Washington St*

\*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

*Calvary Cemetery*

*3/3 1930*

20. UNDERTAKER

ADDRESS

*Arthur J. Donnelly 2034 Wash 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.

2350

Dr. L. H. Thompson

Met. Bldg.

830 - 930 a.m.