

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

APR 30 1930

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

Do not use this space.

10105

1. PLACE OF DEATH

County St. Louis County
Township Central
City St. Vincent's Sanitarium (No. _____)

Registration District No. 289
Primary Registration District No. 6033
St. _____ Ward _____

File No. _____
Registered No. 89
St. _____ Ward _____

2. FULL NAME Mrs. Margaret Shea

(a) Residence. No. 5776 Mrs. Pearson 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 _____

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

7. AGE about 82 yrs. MONTHS _____ DAYS _____ If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. None
(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) Ireland

10. NAME OF FATHER Don't know
11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Ireland
12. MAIDEN NAME OF MOTHER Don't know
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Ireland

14. INFORMANT Sister Raphael, Supt.
(Address) St. Vincent's Sanitarium

15. FILED 3/19, 1930 Polla Gray, V.H.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 17 1930

17. I HEREBY CERTIFY, That I attended deceased from Sept 12, 1926 to Mar 17, 1930 that I last saw h. alive on Mar 17, 1930, and that death occurred, on the date stated above, at 2 P. m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Chronic dyspepsia
93 C.
167
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) Senile dementia
(duration) 4 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) Essequing O'Keefe, M. D.
3/18, 1930 (Address) W. W. W. W.

*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 March 20 1930

20. UNDERTAKER Mullen Theat Co. ADDRESS 165 Belmont

