

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

Do not use this space.

14134

File No. 3466
Registered No. _____
St. _____ Ward _____

1. PLACE OF DEATH

County _____ Registration District No. 791

Township _____ Primary Registration District No. 1003

City St. Louis (No. 19718) (City, Town or Village) _____ St. _____ Ward _____

2. FULL NAME

(a) Residence. No. Missouri St. Mo. Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred 45 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 Widow (write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 9 - 1866

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
63 6 25

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Sawyer
(b) General nature of industry, business, or establishment in which employed (or employer) Unknown
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Mississippi
(STATE OR COUNTRY)

10. NAME OF FATHER J. X. O'Callahan

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Wm. C. Stankov
(Address) City of St. Louis

15. FILED May 11 1930 Wm. C. Stankov REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 3 1930

17. I HEREBY CERTIFY, That I attended deceased from May 14 1930 to June 3 1930 that I last saw him alive on April 3 1930 and that death occurred, on the date stated above, at 6:35 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) 31
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____

IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? No DATE OF _____

20. WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical & X-ray Sputum
(Signed) Carl H. H. H. H. M. D.

4/3 30 (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 St. Matthews Cem DATE OF BURIAL 4/7 1930

20. UNDERTAKER Ziegenhagen Bros ADDRESS 2621 Cherokee

K. 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.

O Callahan

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