

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

Do not use this space.

20956 ~~1054~~

1. PLACE OF DEATH

County.....
Township.....
City.....*St. Louis* (No.)

Registration District No. *791*
Primary Registration District No. *1003*

File No.
Registered No. *5773.*
St. Ward)

2. FULL NAME

Margaret Heade

(a) Residence. No. *1007 Morrison Ave* 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) *Married*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *October 4 1880*

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
<i>ad.</i>	<i>69</i>	<i>8</i>	<i>Unknown</i>	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work *Housework*
(b) General nature of industry, business, or establishment in which employed (or employer) *at home*
(c) Name of employer *Self*

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *New York*

10. NAME OF FATHER *Patrick Cronin*

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

12. MAIDEN NAME OF MOTHER *Mary Heade*

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

14. INFORMANT *James Heade*
(Address) *1007 Morrison Ave*

15. FILED *1930* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *June 13 - 1930*

17. I HEREBY CERTIFY, That I attended deceased from *June 6* 19*30*, to *June 13* 19*30*, and that I last saw her alive on *June 13*, 19*30*, and that death occurred, on the date stated above, at *4:12* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
A purpuric cerebral hemorrhage

CONTRIBUTORY (SECONDARY) *nothing*
(duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? *No* DATE OF

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) *Louis H. Davis* M. D.
13 - 1930 (Address) *107 1/2 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 *Cemetery* DATE OF BURIAL *June 6 1930*

20. UNDERTAKER *W. O. ...* ADDRESS *228 ...*

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.

WRITE FULLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

