

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

Do not use this space.

21398
~~21500~~
File No. _____
Registered No. 6273
St. _____ Ward _____

1. PLACE OF DEATH

County _____ Registration District No. 791
Township _____ Primary Registration District No. 1003
City St. Louis (No. City Hospital)

2. FULL NAME

(a) Residence. No. 6333 Genessee Ward. _____
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE, MARRIED, WIDOWED OR DIVORCED <u>married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>John Moran</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>abt 1869</u>		
7. AGE	YEARS	MONTHS
<u>About 61</u>	<u>Unknown</u>	<u>Unknown</u>
8. OCCUPATION OF DECEASED		
(a) Trade, profession, or particular kind of work. <u>Amsework</u>		
(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)**

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14.

**INFORMANT
(Address)**

15.

FILED

19 21

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3

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

17. I HEREBY CERTIFY, That I attended deceased from June 16 1930 to June 16 1930 that I last saw him alive on June 16 1930, and that death occurred, on the date stated above, at 9:45 a.m.

131. THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic myocarditis
General arteriosclerosis
Chronic nephritis
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTOR (SECONDARY)
129A
(duration) _____ yrs. _____ mos. _____ ds.

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

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS clinical
(Signed) Edward Hedberg M. D.
127 1930 (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 Mt. Olive Cem. DATE OF BURIAL 6/30 1930

20. UNDERTAKER Stoffmeister & Co ADDRESS 1814 Broadway

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.

Moran.