

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

Do not use this space.

24173

**1. PLACE OF DEATH**

County: *St. Louis*  
Township: *Central*  
City: (No. *6240*; Page *BE*)

Registration District No. *789*  
Primary Registration District No. *6033B*

File No. \_\_\_\_\_  
Registered No. *193* St. \_\_\_\_\_ Ward)

**2. FULL NAME**

*Josephine Corey*  
(a) Residence No. *6240*; Page *BE* St. \_\_\_\_\_ Ward. \_\_\_\_\_  
(Usual place of abode)

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 *Michael Corey*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Oct 23 - 1866*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<i>63</i>	<i>8</i>	<i>16</i>	<i>17</i>

8. OCCUPATION OF DECEASED *Housewife*  
(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) *New York*

10. NAME OF FATHER *Unknown*

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

12. MAIDEN NAME OF MOTHER *Unknown*

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

14. INFORMANT *William Corey*  
(Address) *6240*; Page *BE*

15. FILED *7/11* 19 *39* *Rolla Tracy, D.S.* REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *July 9<sup>th</sup> 1930*

17. I HEREBY CERTIFY, That I attended deceased from *1<sup>st</sup> 1930* to *July 9<sup>th</sup> 1930* that I last saw her alive on *July 9<sup>th</sup> 1930*, and that death occurred, on the date stated above, at *7:30* a.m.

THE CAUSE OF DEATH WAS AS FOLLOWS:  
*Chronic Valvular disease of the heart*  
*Mitral insufficiency*  
*92A* (duration) yrs. *4* mos. *9* ds.

CONTRIBUTORY (SECONDARY) *92A* (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 *Chipped ventricle*  
(Signed) *Charles S. Gibson*, M. D.

*July 10, 1930* (Address) *St. Louis, Mo*

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 Cemetery* DATE OF BURIAL *July 12 1930*

20. UNDERTAKER *Callahan Bros* ADDRESS *1710 1/2 Grand 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 important.

AUG 26 1930

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