

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

Do not use this space.

1. PLACE OF DEATH

County.....
Township.....
City..... *St. Louis*

Registration District No. 791
1003

Primary Registration District No. 5300 Maple

File No. 24902
Registered No. 7063
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. _____ St. 5 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 Wm J. Kenefick

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 26, 1847

7. AGE YEARS MONTHS DAY If LESS than 1 day, _____ hrs. or _____ min.
82 11 79

8. OCCUPATION OF DECEASED

(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) St. Louis

10. NAME OF FATHER

Edward Gray

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) England

12. MAIDEN NAME OF MOTHER

Elizabeth Mullen

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Ireland

14. INFORMANT

(Address) Eugene F. Kenefick
5300 Maple

15. FILED

16 1930 Mar C. Standley
19 _____

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 15 1930

17. I HEREBY CERTIFY, That I attended deceased from June, 1925 to July 15, 1930, that I last saw her alive on July 15, 1930, and that death occurred, on the date stated above, at 5:30 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Myocarditis Chronic
930
9019
(duration) 3 yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

Arteriosclerosis (duration) 10 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

C DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? None

(Signed) A. J. Cleveland M. D.

(Address) 3326 Meramec

*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

DATE OF BURIAL

Calvary July 18 1930

20. UNDERTAKER

ADDRESS 1415

Hannigan & Sheehan Washington
DC

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.

