

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

Do not use this space.

24935

1. PLACE OF DEATH

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

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

File No.....
Registered No. *7099*
St..... Ward.....

2. FULL NAME

(a) Residence No. *6227 Reber Place* St. *3* 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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *May 15 - 1869*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
61 *2* *—* *—*

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Cook*
(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) *Ireland*

10. NAME OF FATHER *Thomas Green*

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

12. MAIDEN NAME OF MOTHER *Ant. Konow*

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

14. INFORMANT *Mrs. Mary Kirwan*
(Address) *6227 Reber Place*

15. FILED *17 1930* *May C. Starker* 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 *July 15 1930* to *July 15 1930*, 19*30*, and that I last saw him alive on *July 15 1930*, and that death occurred, on the date stated above, at *12 P. m.*

THE CAUSE OF DEATH WAS AS FOLLOWS:

107A
95 B
Benign Pneumonia
(duration) yrs. mos. ds.

CONTRIBUTORY *Ant. cardiac Distention* (SECONDARY)
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED *1000*
IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) *R. B. B. B. B.* M. D.

(Address) *3165 E. Grand*

*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 *Cabany* DATE OF BURIAL *July 18 1930*

20. UNDERTAKER *Edw. H. Howard & Son* ADDRESS *4212 St. Louis Ave*

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.

RECORD WITH ORIGINAL RECORDING TAP—THIS IS A PERMANENT RECORD

