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.

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

Do not use this space.

25364

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. .....

Township ..... Primary Registration District No. 2003 Registered No. 7598

City St. Louis, (No. Deaconess Hospital St. ..... Ward)

2. FULL NAME Thomas Howard Mac Queary

(a) Residence. No. 6619 Kingsbury St., 4 Ward. St. Louis Co. Mo
(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	white	married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Emma H. Mac Queary

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 27-1861

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	69	2	X	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work School Professor
(b) General nature of industry, business, or establishment in which employed (or employer) Soldan High School Retired.
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Albamarle Co
(STATE OR COUNTRY) Virginia

PARENTS

10. NAME OF FATHER Thomas Howard MacQueary
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Virginia
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Sarah J. Garland
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Virginia
(STATE OR COUNTRY)

14. INFORMANT Mrs Emma H. Mac Queary
(Address) 6619 Kingsbury

15. FILED JUL 29 1930 Max C Starkey REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 27, 1930.

17. I HEREBY CERTIFY, That I attended deceased from June 6th, 1930, to July 27, 1930 that I last saw him alive on July 27, 1930, and that death occurred, on the date stated above, at 8.30 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Myocarditis. Chronic
186A
194B
93C
(duration) yrs. 6 mos. ds.

CONTRIBUTORY (SECONDARY) Fracture Femur, right
falling to floor, Academy
(duration) yrs. 5 mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) L. Wosburgh, M. D.
July 28, 1930 (Address) 832 Metropolitan Bldg

*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
Delavan Wisconsin	July 30 1930

20. UNDERTAKER CR Lupton ADDRESS 4449 Olive

Dr. J. W. Kerner Dep. Cor. 7/29/30

VOSburgh

AGE should be

Metropolitan Bldg
Jeff 4141
11 a.m.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. .....

Township ..... Primary Registration District No. 1003 Registered No. 75-98

City St. Louis (No. ....., ... St. ..... Ward)

2. FULL NAME Thomas Howard MacRuery

(a) Residence. No. ..... St., ... 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
M	W	M

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

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

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(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)

PARENTS

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 DEC 29 1930 Max C. Starkloff Jr. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 27 1930

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19....., and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Fractured femur at Falling to floor accident

..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? At home information given over phone by Dr. L. M. Vosburgh

DID AN OPERATION PRECEDE DEATH? ..... DATE OF Div. of W.S. 9-22-30

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) ..... M. D

, 19 (Address) 185

*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 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

5-25364