

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.

Dr. K. M. ...
1117 N Grand
2-4

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

Do not use this space.

25371

1. PLACE OF DEATH

County
Township *St. Louis*
City *St. Louis* (No. *St. Louis*)

Registration District No. *791*
1003

Primary Registration District No. *Waltham*

File No.
Registered No. *7605*
St. Ward)

2. FULL NAME

(a) Residence. No. *4866* *Bessie* St. *9* 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) *Married*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Sept 3 1890*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
39 10 24

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work *House Work*
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *St. Louis* (STATE OR COUNTRY) *Mo.*

10. NAME OF FATHER *Joseph P. Dohy*

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

12. MAIDEN NAME OF MOTHER *Kate O'Hara*

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

14. INFORMANT *Mr. Mary Dries* (Address) *4866 Bessie*

15. FILED *JUL 29 1930* *Max C. Stankov* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. HEREBY CERTIFY, That I attended deceased from *July 1* 19*30* to *July 27* 19*30*, that I last saw him alive on *July 27* 19*30*, and that death occurred, on the date stated above, at *8:30 P.* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Exophthalmic goiter - toxic type
93 D (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) *Myocardial changes* (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED *600 W* IF NOT AT PLACE OF DEATH

1 DID AN OPERATION PRECEDE DEATH? *yes* DATE OF *July 26-1930*

2 WAS THERE AN AUTOPSY? *no*
WHAT TEST CONFIRMED DIAGNOSIS *Boon Mitchell* (Signed) *R. Cummings*, M. D.

July 27, 1930 (Address) *1117 N 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 *Calvary* DATE OF BURIAL *July 30 1930*

20. UNDERTAKER *Chas. Kelly* ADDRESS *4524 Easton*

