

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

Do not use this space.

27928

1. PLACE OF DEATH

County.....
Township.....
City.....

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

File No.....
Registered No. **7742**
St..... Ward.....

2. FULL NAME

(a) Residence. No. **2832 N Union Blvd** Ward. **6**
(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 **Female**
4. COLOR OR RACE **White**
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Married**
6. IF MARRIED, WIDOWED OR DIVORCED, HUSBAND OF (OR) WIFE OF **Joseph P. Schwartz**

7. DATE OF BIRTH (MONTH, DAY AND YEAR) **abt 1852**

8. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.
abt 68 **Unknown**

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

10. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Ireland**

11. NAME OF FATHER **Ed Cagney**

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

13. MAIDEN NAME OF MOTHER **Wukom**

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

15. INFORMANT (Address) **Joseph P. Schwartz 2832 N Union Blvd**

FILED **AUG -2 1930** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Aug 1 1930**
17. I HEREBY CERTIFY, That I attended deceased from **July 3rd** 19**30** to **July 31 1930** that I last saw her alive on **July 31 1930** and that death occurred, on the date stated above, at **5:15 A.M.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cancer of Uterus
48

(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) **46**
(duration) yrs. 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) **Dr. Fred Crowe M.D.**
19 (Address) **5738 W. Florissant**

*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 Cemetery** DATE OF BURIAL **Aug 1930**

20. UNDERTAKER **Chas. L. Sneyd** ADDRESS **4259 Lindell**

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.

