

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

Do not use this space.

27976

1. PLACE OF DEATH

County.....
Township.....
City.....
Registration District No.....
Primary Registration District No.....

File No.....
Registered No. 17803
St..... Ward.....

2. FULL NAME

(a) Residence. No. 4148 N. Grand St., 10 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

MEDICAL CERTIFICATE OF DEATH

3. SEX
4. COLOR OR RACE
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Male
Wht
Widowed

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 4 1930

17. I HEREBY CERTIFY, That I attended deceased from
19....., 19....., to....., 19.....

that I last saw him..... alive on....., 19....., and that death occurred, on the date stated above, at.....

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Haemorrhage of Brain
Fractured Skull
Acute Lobar Pneumonia
Stroke by Auto

CONTRIBUTORY (SECONDARY) Whether Criminal or Not
Whither Criminal or Not

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

8. DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) J. W. Kerner, M.D.
8/5, 1930 (Address) Dep. Coroner

*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

20. UNDERTAKER
ADDRESS

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

Josephine Botz

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 14 1871

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.

58 10 20

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Stationary 2100
(b) General nature of industry, business, or establishment in which employed (or employer)..... Engineer
(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Ind.

10. NAME OF FATHER

John O' Mara

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Ireland

12. MAIDEN NAME OF MOTHER

Do not know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Ireland

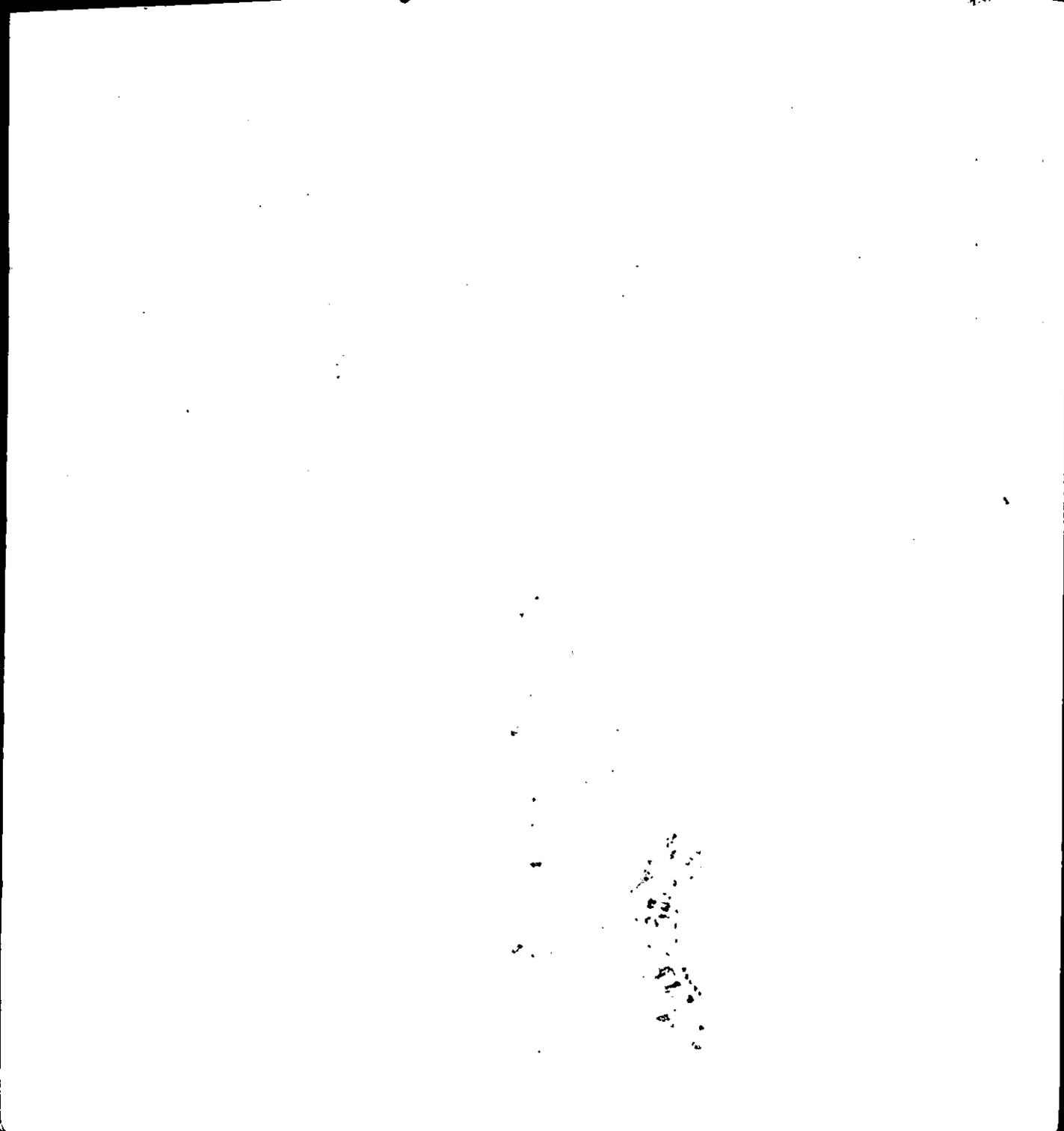
14. INFORMANT.....

(Address) 4148 N. Grand

15. FILED..... 19.....

REGISTRAR

Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified.



**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County St. Louis Registration District No. 791 File No. _____
 Township _____ Primary Registration District No. 1003 Registered No. 7803
 City St. Louis (No. _____) St. _____ Ward _____

2. FULL NAME

Michael O'mara

(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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) wid

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 4 1930

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

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

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.

Perforation of Brain
fractured skull
struck by auto
while crossing street

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

CONTRIBUTORY (SECONDARY)

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY)

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

10. NAME OF FATHER

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

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

WAS THERE AN AUTOPSY? _____

12. MAIDEN NAME OF MOTHER

WHAT TEST CONFIRMED DIAGNOSIS? _____

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

(Signed) _____, M. D.

_____, 19 _____ (Address)

*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.

14. INFORMANT (Address) _____

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL _____

15. FILED 1930-07-19 Max C. Starkloff REGISTRAR

20. UNDERTAKER _____ ADDRESS _____

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW. CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCURRING.

SUPPLEMENTARY

5-27976