

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

Do not use this space.

28184

1. PLACE OF DEATH

County..... Registration District No. 791
Township..... Primary Registration District No. 1003
City St. Louis Mo. (No. Barward Hospital) St. (Ward)

File No.
Registered No. 8025
St. (Ward)

2. FULL NAME

Margaret Raleigh
(a) Residence. No. St. Ignace St., 5 Ward. (If nonresident, give city or town and State)
(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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Unknown
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. About 65

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

9. BIRTHPLACE (CITY OR TOWN) New Orleans
(STATE OR COUNTRY) Louisiana

PARENTS
10. NAME OF FATHER John Raleigh
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Louisa
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Mary Hargan
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) St. Paul
(STATE OR COUNTRY)

14. INFORMANT Alphonse Shure
(Address) 4467 Pershing

15. FILED AUG 11 1930 Wm C Starley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug. 9 1930
17. I HEREBY CERTIFY, That I attended deceased from Aug 4 1930, to Aug 9 1930 that I last saw h. alive on Aug 9 1930, and that death occurred, on the date stated above, at 4:30 P.M.
THE CAUSE OF DEATH* WAS AS FOLLOWS:

Carcinoma of Rectum.
460 (duration) yrs. 6 mos. ds.

CONTRIBUTORY (SECONDARY) 45 (duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? Yes DATE OF Aug 7-1930

19. WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical and Operator
(Signed) Jay N. Maguire, M. D.
(Address) 3427 Washington

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state MEANS AND NATURE OF INJURY, and (3) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. St. Louis, Mo.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Calvary DATE OF BURIAL 8-17-30

20. UNDERTAKER Hargan & Sheahan ADDRESS 1415 Washington

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.

