

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

Do not use this space.

28396

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... **1003**
City **St. Louis** (No. **2919**, **Abner Place**)

File No.....
Registered No. **8271**
St..... Ward.....

2. FULL NAME **Bridget Riley**

(a) Residence. No. **2919 Abner Place** St. **6** 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 *Widow*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Dec 10 - 1864*

7. AGE
YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
65 8 7

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work *at home*
(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 *John J. O'Connor*

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

12. MAIDEN NAME OF MOTHER *Unknown*

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

14. INFORMANT *William Riley*
(Address) *2919 Abner Place*

15. FILED *Aug 19 1930*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Aug. 17th 1930*

17. I HEREBY CERTIFY, That I attended deceased from *Jan 1*
1930 to *Aug 17 1930*
that I last saw her alive on *Aug 10 1930* and that death occurred, on the date stated above, at *10:45 a. m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Apoplexy cerebral
Hemorrhage
107 (duration) yrs. mos. *1/2 hour*

CONTRIBUTORY (SECONDARY) *Hyperextension*
Disseminated (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? *Physical signs*
(Signed) *Wm. M. ...* M. D.

Aug 18 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 Cemetery* **DATE OF BURIAL** *Aug 20 1930*

20. UNDERTAKER *Cullman Bros 170 N Grand St*
ADDRESS

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.

